

*President's Message*

# The Quality of American Health Care: Can We Do Better?

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Not long ago, we asked our Harkness Fellows — health care experts visiting the United States from the United Kingdom, Australia, and New Zealand—how the American health care system compares with their own. Uniformly, they replied that although our specialty care has much to commend it, they would strongly prefer to be cared for at home if they became ill. In their view, health care in the United States is hard to navigate, poorly coordinated, expensive, and lacking in attention to basic primary care services.

Their answers jostled my complacency. Having heard over and over that American health care is the best in the world, I found it startling to be told “the

best care is at home” by knowledgeable people from very different health care systems. It set me wondering whether the quality of American health care is truly the best in the world, and how we would know if it were.

## WHAT IS QUALITY CARE?

The fact is, we know frustratingly little about quality of care. We do know that the United States spent \$1.15 trillion on health care in 1998, up 5.6 percent from the year before. We know, as well, that 42.6 million people were uninsured in 1999. These numbers tell us that access to care is difficult for many and that costs are rising, yet they offer scant insight into the actual quality of care being delivered by the American health care system. The problem is partly one of definition, partly one of method, and partly logistical. How do we define high-quality care, how do we measure it, and how do we gather data on the things we know how to measure?

The Institute of Medicine defines quality as “the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.” More simply, from a practicing physician’s point of view, good quality means doing the right thing in the right way at the right time. But patients want more than technically competent care. High on their list of priorities is information — information about their conditions, treatment options, realistic expectations for the future, and what they can do to be active

partners in their care. From a patient's point of view, good quality means providing care and information in a way that works for the patient at the time the patient wants it.

Achieving high quality — from a physician's point of view or a patient's, and preferably from both — is a challenge that demands new thinking and fundamental change in American health care. Gaining a better understanding of how our health care system is currently doing is an important first step. The Fund's work is increasingly focused on furthering that understanding and stimulating quality improvement.

#### AN INTERNATIONAL PERSPECTIVE: WHAT CAN WE LEARN?

The World Health Organization (WHO) recently took a first stab at answering the question of which country has the best health system. The product of that effort, *World Health Report 2000*, can be criticized for the indicators selected, the data gathered, or the methods of combining indicators and assessing performance, but its determination to rank health systems around the world has given new impetus to international comparisons of quality of care and health system performance. The report includes two measures directly related to quality of care: disability-adjusted life expectancy and responsiveness to patients.

The emphasis on responsiveness to patients is particularly welcome, encompassing as it does such aspects of

patient-centered care as respect for the dignity of the patient, confidentiality, autonomy to participate in decision making, prompt attention, amenities, access to social support, and choice of provider. In the absence of concrete data on those elements, the WHO relied on judgments by key informants. Despite the obvious weakness of this method, the results are interesting. The United States ranked first out of 191 countries on responsiveness to patient expectations, but 24th on disability-adjusted life expectancy, a category in which Japan placed first.

These conclusions are confirmed by analyses conducted by The Commonwealth Fund. Since 1998, for example, the Fund's annual international health policy surveys have shown far shorter waiting times for nonemergency surgery in the United States than in Australia, Canada, New Zealand, or the United Kingdom. Indeed, very few Americans wait significant periods for surgery, tests, or referrals to specialists. Fund-supported studies also confirm that the United States has lower mortality from heart attacks than Australia, Germany, New Zealand, or the United Kingdom, although we are somewhat behind Canada and considerably behind France and Japan in this area. The five-year survival rate for breast cancer is higher in the United States than in Australia, England, France, Germany, or Japan, and the prostate cancer mortality rate is lower than in Australia, Canada, Germany, New Zealand, or the United Kingdom. By contrast, the United States

**Waiting long periods for nonemergency surgery—a source of dissatisfaction among patients—is common in some countries but rare in the United States.**

Percent who reported waiting 4 months or more for nonemergency surgery for themselves or a family member

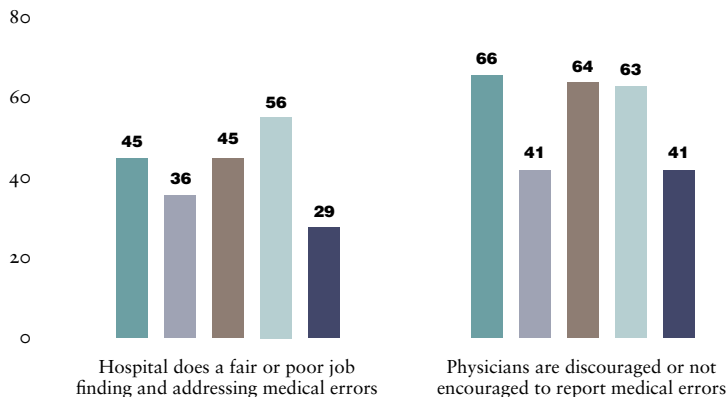


Source: The Commonwealth Fund 1998 International Health Policy Survey.

**Many U.S. physicians are skeptical about their hospitals' ability to recognize or address medical errors, yet doctors in other countries are even more likely to give their institutions poor grades.**



Percent of generalist physicians



Note: Some physicians report that their institutions have no process for tracking medical errors.

Source: The Commonwealth Fund 2000 International Health Policy Survey of Physicians.

has the worst record among these major industrialized countries on infant mortality and low birthweight babies—grim indicators of lost years of life that help account for our low ranking on the WHO measure of disability-adjusted life expectancy.

The Fund's 2000 International Health Policy Survey of Physicians focused specifically on physician views of the quality of care in their health care systems. American physicians, compared with their counterparts in Australia, Canada, New Zealand, or the United Kingdom, tend to give their system higher ratings on being "up to date" in terms of medical and diagnostic equipment and surgical and emergency facilities. American physicians give hospitals more credit for dealing with medical errors than do their counterparts in other countries, yet it is still true that nearly one-third of U.S. primary care physicians say their hospitals do only a fair or poor job of finding and addressing medical errors, and 42 percent say they are either discouraged from reporting medical errors or not encouraged to report them. Overall, nearly 60 percent of U.S. physicians perceive their ability to provide quality care as having worsened over the last five years, and only one in five is very satisfied with the practice of medicine.

This dichotomy in American health care—doing well at the complex end of the scale and not so well at the basic—is confirmed by other research. Fund-supported studies find that, per capita,

the United States does far more cardiac procedures (including catheterization and coronary bypass surgery), has more cardiologists, and gives beta blocker medications more consistently to post-heart attack patients than is the case in the United Kingdom, characteristics that may contribute to our much lower rate of coronary heart disease mortality. Similarly, our high five-year survival rate for breast cancer may be partly attributable to our much larger supply of medical oncologists and radiation therapy facilities and personnel. Studies comparing the quality of primary care across countries, however, do not give the United States high marks on such aspects as patients' having a regular source of care or continuity of care with the same doctor.

These findings suggest that the United States can do better, even in areas where it is already doing well. A system that improves primary care, prevents medical errors, and provides critical information to physicians and patients is badly needed. International experiences offer many opportunities to learn from best practices and innovation around the world, and to work for better health care for all.

#### MEASURING AND REPORTING ON CLINICAL QUALITY

A national system for reporting on the quality of American health care is now under development by the U.S. Agency for Healthcare Research and Quality. Until that system is ready, sometime in the next two to three years, the primary source of health care quality data is

the National Committee for Quality Assurance (NCQA), a nonprofit organization that accredits health maintenance organizations (HMOs) and reports on their performance. NCQA's *Quality Compass* data base, developed with a loan from The Commonwealth Fund, includes 466 HMOs and point-of-service plans that choose to participate. Together, these plans cover more than 51 million Americans, or about one-fifth of the U.S. population.

NCQA gauges quality according to a set of measurements collectively known as HEDIS (Health Plan Employer Data and Information Set) indicators. These include both clinical categories and enrollees' ratings of the care they receive through their health plans. Clinical HEDIS measures include preventive services, such as screening and immunizations; physician counseling; proper management of chronic conditions such as asthma, diabetes, high blood pressure, or mental illness; and appropriate care and follow-up of acute conditions, such as heart attack or pregnancy. For the second consecutive year, the 2000 *Quality Compass* data show a strong association between high ratings on clinical quality and members' own ratings of their care.

Releasing HEDIS data to the public has contributed to steady improvements over time, lending support to the belief that what gets measured gets improved. When NCQA first reported the use of beta blocker treatment after heart attack in 1996, for example, the percentage

of patients receiving the treatment was 62 percent. By 1999, the rate had risen to 85 percent, an improvement that has saved an estimated 2,125 lives. The average rate for chicken pox vaccine was 40 percent in 1997 but jumped to 64 percent in 1999. In general, plans that reported data for three years saw their ratings increase over time.

Progress notwithstanding, great variations in quality continue to distinguish individual health plans, geographic regions, and types of plan. NCQA estimates that if all plans performed as well as those ranked at the 90th percentile, 57,500 episodes of relapse back into major depression would be prevented, 4,280 cardiac deaths per year would be avoided, 456,000 more women would

be screened for breast cancer, 300 deaths from breast and cervical cancer would be prevented, 82 percent of children's unnecessary morbidity and mortality would be avoided, and the incidence of low birthweight infants would be reduced. Since these estimates take account only of managed care plans reporting data to NCQA, similar improvements in the rest of the health care system could multiply those gains several times over.

Clinical quality often suffers when physicians miss opportunities to encourage or provide preventive care. According to current estimates, only 61 percent of women over 50 have had a mammogram in the last year and only 64 percent of adult women have had a Pap smear. Among men, 41 percent

**Quality information helps purchasers identify the best health care value, and it can also spur improvement. Among plans reporting data to NCQA, some important indicators—such as chicken pox vaccine and use of beta blocker treatment after heart attack—have risen dramatically since HEDIS data were first reported in 1996, and new indicators may prompt comparable gains. Still, gaps between top performing and bottom performing plans remain large.**

Percent of patients receiving treatment, by selected HEDIS clinical indicator

	1996	1999 All Plans	1999 90th Percentile Plan	1999 10th Percentile Plan
Adolescent immunizations	52%	59%	85%	31%
Advising smokers to quit	61	65	73	56
Beta blocker treatment after a heart attack	62	85	96	70
Breast cancer screening	70	73	82	64
Cervical cancer screening	70	72	83	60
Chicken pox vaccine	40*	64	76	50
Childhood immunizations	65	64	81	46
Cholesterol screening after a heart attack	—	69	83	53
Diabetic eye exam	38	45	66	28
Follow-up after hospitalization for mental illness	72	70	86	51
Prenatal care in the first trimester	83	85	95	71

\* 1997

Source: National Committee for Quality Assurance, *The State of Managed Care Quality*, 2000.

received no preventive care at all—no physical exam, no blood cholesterol tests, no prostate or colon cancer screening. Of men who did see a physician, less than half were advised about diet and exercise, only a third were counseled about smoking, less than a fourth received information about the use of alcohol and drugs, and only a small fraction discussed sexually transmitted disease or safety and violence at home. Less than a third of men over 40 have ever talked with their physicians about a family history of prostate cancer. Rates of counseling for women are similar.

Quality may also be compromised by less than full adherence to clinical guidelines. For example, although the Fund's 2000 International Health Policy Survey of Physicians found that 90 percent of U.S. physicians say they follow clinical guidelines, other studies show that day-to-day practice often falls short. We know that only about half of diabetics receive an annual eye exam, that only about half of patients with hypertension have their blood pressure controlled, and that only about one-fifth of patients with clinical depression are treated with antidepressant medications.

#### MEDICAL ERRORS: WHAT CAN BE DONE?

Many failures of quality reflect a health care system that depends, perhaps too heavily, on human memory and judgment. A landmark study, *To Err is Human*, published this year by the Institute of Medicine with partial support from the Fund, underscores the

risks inherent in such a system. The report estimates that between 44,000 and 98,000 Americans die in hospitals each year as a result of medical errors—more than from motor vehicle accidents, breast cancer, or AIDS. Errors in non-hospital settings (such as physicians' offices, pharmacies, and nursing homes) or as a result of outpatient surgery are not included. A common source of errors is misinterpretation of physicians' written orders. One study calculates that as many as half of medication errors could be prevented with computerized order entry systems. Another common problem is inadequate coordination across multiple providers and sites of care.

One predictor of results is the number of times a physician, team, or hospital has cared for patients with the same condition. An Institute of Medicine report documents the relationship between volume of procedures and mortality rates, adjusted for the complexity of cases among the patients served. What remains unclear is whether the association between better results and more procedures reflects the maxim that "practice makes perfect" or is simply a function of high-volume clinicians following better processes. Further, the association between doing more and getting better results does not always hold, since some high-volume centers have higher mortality rates than low-volume centers. Nonetheless, some rules of thumb regarding minimum desirable volume have been developed. A 1997

**In general, patients tend to do better in hospitals that handle high volumes of the particular procedures they need. Although this finding does not hold true for all institutions, statistical analysis allows researchers to pinpoint minimum thresholds for best patient outcomes.**

Hospitals' suggested annual minimum number of procedures for best outcomes

Procedure	Annual Minimum
Coronary bypass	500
Coronary angioplasty	400
Carotid endarterectomy	100
Pediatric heart surgery	100
HIV/AIDS patients	100
Prostate surgery	55
Abdominal aortic aneurysm repair	32
Cerebral aneurysm repair	30
Mastectomy	25
Major liver surgery	11
Heart transplant	9
Esophageal cancer surgery	7
Pancreatic cancer surgery	7

Source: R. A. Dudley et al., "Selective Referral to High-Volume Hospitals: Estimating Potentially Avoidable Deaths," *Journal of the American Medical Association*, March 1, 2000.

study of California hospitals estimated that 600 out of 2,273 deaths would not have occurred if low-volume hospitals had had the same mortality rates as high-volume hospitals.

An informed patient might wish to know which clinicians and centers do more than the minimum recommended volume of procedures, as well as their records on risk-adjusted mortality, complications, or other outcomes. Good sources for this information are quite limited. Some states, including New Jersey, New York, and Pennsylvania, make data on cardiac surgery volumes and outcomes available by name of surgeon and by hospital. California,

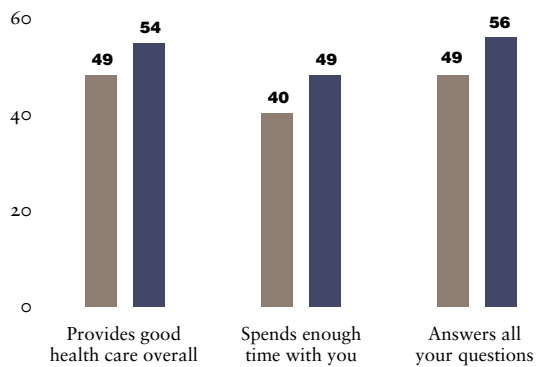
Florida, Illinois, Maryland, New Jersey, New York, and Pennsylvania report hospital volume for breast cancer surgery, and several states do so for colon cancer surgery. The Pacific Business Group on Health, a business purchasing coalition, publishes data on volume of surgeries for hospitals in California and some regions of the Northwest. Consumer organizations in some states have also begun compiling and listing information on the internet. Yet the fact remains that most reporting hospitals do less than the recommended minimums.

At least in theory, releasing performance data to the public can promote informed consumer choice, improve quality, and reduce mortality or complications. It can spur internal quality improvement on the part of hospitals and physician organizations, help governmental regulators set and enforce minimum quality standards, and assist employers and managed care plans in influencing the quality of health plans. A summary of the literature by Harkness fellow Martin Marshall, M.D., and colleagues found that, among providers, hospitals seem to be the most responsive to quality-of-care data. Hospitals use quality information to review procedures, implement internal changes, and alter behaviors, as well as to examine their own performance relative to that of peer institutions.

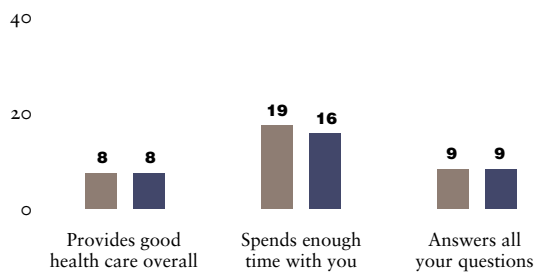
**When asked about the care provided by their regular doctors, only about half of patients gave their physicians excellent overall ratings, with women offering somewhat higher marks than men. Nearly one-fifth of men rated their doctors fair or poor on spending enough time with them.**

■ Men  
■ Women

Percent of patients, ages 18–64, giving their physicians excellent ratings



Percent of patients, ages 18–64, giving their physicians fair or poor ratings



Source: The Commonwealth Fund 1998 Survey of Women's and Men's Health.

## WHAT "QUALITY" MEANS TO PATIENTS

Patients want technically competent care, the best odds for survival, and minimal complications or impairment. Yet an overwhelming volume of Fund-supported work over the past 15 years shows that patients also want good information. Patients with health problems want to understand their conditions, their treatment alternatives, and what they can expect after surgery or hospital discharge. They want their family members to get the information they need, and they want to know what they can do to improve their chances of full recovery. Healthy patients want to know what they can do to prevent chronic conditions and maintain their health. Parents want information about what they can do to help their young children grow and learn. As Donald Berwick, M.D., president of the Institute for Healthcare Improvement in Boston, has said, "Information *is* care."

Patients also value access, whether that means ease in getting an appointment, convenient hours, short waiting times, prompt response to phone inquiries, or communication through mechanisms such as e-mail. A physician who listens, explains clearly, treats patients with respect, and builds a trusting relationship is important to patients. Physicians who are effective at helping patients adopt healthier behaviors—by changing their diet, exercise, or smoking habits, for example—are providing those patients with better care.



In addition, patients want their primary care physicians to coordinate their care across sites and to be able to refer them to the right specialists, home care agencies, and nursing homes. These are high expectations—difficult for physicians in busy practices to meet. The challenge is intensified by the fragmentation and specialization inherent in our health care system, which excels at technically competent care for highly specialized procedures but too often falls short in terms of continuity.

The Fund and others have invested in capturing patients' views about their care, a process that should lead to greater awareness among physicians. The Fund's 2000 International Health Policy Survey of Physicians indicates that 41 percent of American doctors often use patient satisfaction reports to review the care they provide, and almost half of primary

care physicians and a third of specialists say they find those reports (or think they would find them) very useful. The Fund's national surveys collect patients' views on how well the health care they receive meets their perceived needs. Only about 54 percent of women and 49 percent of men rate their physicians as excellent overall in providing health care. Physicians tend to receive high marks for treating patients with dignity and respect but low marks for spending enough time with their patients.

Patient ratings of care are now incorporated into managed care quality reporting systems, and aggregate statistics on various patient-centered dimensions of care are available by plan. Among the plans that report CAHPS (Consumer Assessment of Health Plan Study) data, the average share of enrollees who say their health care rates 8 or higher on a 10-point scale is 70 percent, ranging from 62 percent for plans at the 10th percentile to 78 percent for plans at the 90th percentile. Variations also occur in patients' ratings of their doctors or nurses, access to needed care, speed in getting care, and courtesy and helpfulness of office staff. Patients rarely have access to ratings on individual physicians, however, when trying to find a physician who will be responsive to their concerns.

Patient satisfaction data on individual hospitals is beginning to be released to the public. A 1998 survey of 13,000 patients discharged from 58 Massachusetts hospitals, conducted by the Picker Institute for the Massachusetts Health Quality Partnership, was made publicly available

**Data from the Consumer Assessment of Health Plan Study (CAHPS) provides a snapshot of patients' experiences with managed care and the quality of care they receive. Patient ratings are available for approximately 300 plans through NCQA's Quality Compass database.**

Selected CAHPS member ratings of care, 1999

	Percent Satisfied*	90th Percentile Plan	10th Percentile Plan
Rating of health plan	70%	78%	62%
Getting needed care	74	83	65
Getting care quickly	78	85	71
Courteous and helpful office staff	91	95	87
Customer service	65	74	56
Claims processing	78	90	66
Rating of personal doctor or nurse	73	80	66
Rating of all health care	70	78	62

\*Depending on measure, represents percent of members reporting not a problem, usually or always, or 8–10 out of a maximum score of 10.

Source: National Committee for Quality Assurance, *The State of Managed Care Quality*, 2000.

and was widely reported by the media. The study is notable because it represents the first time hospitals across an entire state have participated voluntarily in a survey using consistent methodology and agreed to make the results publicly available. More important, patients' responses to the survey, along with other quality measurement and improvement projects, are driving a range of efforts to upgrade performance in Massachusetts hospitals. Similar efforts are under way in Colorado and California.

As important as these advances are, they provide only a tantalizing taste of what could be gained by capturing and disseminating information on how patients experience the quality of their health care. Considerable barriers—including professional reluctance to undergo scrutiny, methodological issues in measuring and adjusting data, and the high cost of surveys large enough to generate good information on the nation's 6,000 hospitals, 600,000 practicing physicians, and 16,000 nursing homes—are daunting. Even so, advances in information technology and the growing desire of the public for information about their own health care may help propel such a movement.

#### HIGH-QUALITY CARE FOR ALL

A fairly large body of research has documented that vulnerable groups of patients—those with low incomes or limited education, who lack health insurance coverage, or who are members of minority racial or ethnic groups—tend

to face special problems in getting access to health care. On the issue of health care quality, however, less has been written.

In fact, access and quality are closely intertwined. Because people in underserved or vulnerable groups are less likely than average to have a regular doctor and more likely to use emergency rooms when they become sick or are injured, their care tends to be episodic. Without good continuity of care, they are less likely to receive preventive care and counseling and more likely to have trouble getting the care they need to manage chronic or complex conditions. For example, a Fund-supported study of Medicare beneficiaries found that elderly African Americans are half as likely as whites to undergo coronary bypass surgery or receive a hip replacement and more than three times as likely to have a lower limb amputated, a reflection of poor care for conditions such as diabetes.

Systematic data on the quality of care for underserved populations are very limited. The current major source of national quality information—HEDIS indicators—is not available by race or ethnicity. A Fund-supported project is investigating differences in quality of care among whites, blacks, Hispanics, and Asian Americans in six managed care plans, but most plans do not identify patients by race or ethnicity and do not report data by patients' income, education, and race or ethnicity.

Another Fund-supported project is working with state Medicaid programs to collect HEDIS data on Medicaid managed care plans. Baseline results in the first year, covering 110 plans in 21 states, show substantial differences among Medicaid plans, as well as between Medicaid plans and health plans serving employer-based groups. For example, although 41 percent of diabetic Medicaid enrollees had received a retinal eye exam during the previous year, scores for individual plans ranged from 10 percent to 99 percent. Medicaid plans scored lower than commercial plans on seven of nine benchmark clinical measures. Currently, 180 Medicaid managed care plans in 29 states are participating in the project and sharing data.

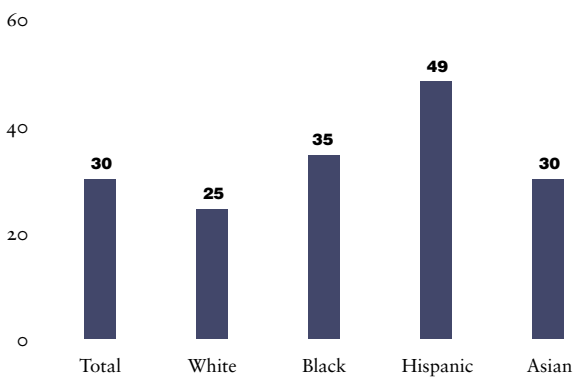
National survey data are quite clear in indicating failures by the health care system to deliver preventive care to

vulnerable populations. Analyzed by income, women in the bottom fourth of the income distribution are twice as likely as women in the top fourth to say they received no preventive services in the past year. Similarly, women with less than a high school education or without health insurance are twice as likely to receive no preventive care as their college-educated or insured counterparts. Hispanic and Asian American women are more than half again as likely as white women to receive no preventive care, although African American women receive preventive care, including mammograms and Pap tests, at higher rates than white women. The situation is even worse among men, who are nearly three times as likely as women to have received no preventive care in the last year. During the twelve months before they were surveyed, two-thirds of uninsured men and half of men in the bottom quartile of the income distribution received no preventive services.

Patient ratings of health care vary considerably by income, education, insurance status, and race or ethnicity. Lower-income patients are more likely to rate their physicians as fair or poor on such dimensions as good health care overall, spending enough time, answering questions, and making sure the patient understands what the doctor has said. Hispanic men and women are much more likely to rate their physicians as fair or poor than are whites or African Americans. About one-fourth of Hispanics feel that their physicians do

**Without a regular doctor, patients miss out on preventive care and counseling that can help them maintain their health, especially if they have a chronic condition such as asthma or diabetes. A recent Fund survey showed that minority patients are especially likely to have no regular doctor.**

Percent of adults, ages 18–64, without a regular doctor



Source: The Commonwealth Fund 1998 Survey of Women's and Men's Health.

not spend enough time with them, and about one-fifth say their physicians do not care about their health or answer all their questions.

Special quality-of-care issues also exist for young children. The Fund is working with pediatric providers to ensure that parents receive vital information about what they can do to help their young children get a healthy start in life, be ready to learn in school, and grow into productive adults. Healthy Steps, an innovative model for enhancing child development information and services, is now being tested. At the same time, the Fund is engaging Medicaid programs in four states—North Carolina, Utah, Vermont, and Washington—to improve child development services for low income families. Unfortunately, these promising efforts are reaching only a small portion of families that want and would benefit from this kind of pediatric care.

Frail elders warrant particular attention, as well. Over the last decade, Fund-supported projects have helped to reduce the use of physical restraints in American nursing homes from 40 percent to 15 percent of all residents. Other quality-related problems, however, such as malnutrition and dehydration, continue at alarming rates. Given the current climate of financial stringency, staff shortages, and high turnover in the nursing home sector, the Fund has sought new approaches to improve the

quality of care with existing personnel. One unusual model has been developed by Wellspring, Inc., an alliance of 11 nursing homes in eastern Wisconsin, which brings front-line staff together to identify problems and generate solutions, while senior managers systematically measure and compare results. With Fund support, an evaluation is testing the effectiveness of the Wellspring model in improving quality and reducing staff turnover.

Better information and a stronger commitment to high-quality health care for all are urgent priorities, given the dramatic growth in minority populations projected over the next few decades. Racial or ethnic minorities represent 28 percent of the U.S. population today, but that figure is expected to reach 40 percent by 2030, with especially rapid growth among Hispanic and Asian American populations. Cultural, language, and literacy barriers intensify the traditional problems caused by lack of health insurance and low income. It is clear that many physicians and health care organizations are not well equipped to serve an increasingly diverse patient population. Fund-supported work is addressing this gap by identifying best practices for providing culturally competent care—a step toward changing medical education and the delivery of health services.

### THE QUEST FOR QUALITY

Clearly, the struggle for health care quality will need to take place on at least two fronts. Even as we seek to redress current inequities, we must also look ahead to future challenges. The best modern medicine has to offer is not available to all Americans today, and the future quality of health care may be jeopardized by forces that place too great an emphasis on reducing costs.

As detailed in this *Annual Report*, The Commonwealth Fund will be devoting its energies over the next five years to helping patients become better informed and more active partners in their care and to encouraging physicians and health care organizations to improve the quality of care they deliver. We hope to engage a broad spectrum of individuals and organizations, including business leaders, consumer groups, physicians and other health care providers and their professional organizations, hospitals and health care institutions, insurers, and state and federal government. All stand to benefit from a health care system that learns from international examples as well as best practices in the United States, attends more carefully to clinical quality, addresses its mistakes, heeds the wishes of patients, and provides equitably for all patients.

The Fund has a long history of commitment to improving health care, especially for groups with serious and neglected problems. Through the years,

we have been strong believers in the power of good information, the fundamental importance of professionalism in health care, the need for access to the best available services, care that is responsive to patients, and the ability of the health care system to change for the better. We are confident that those principles will continue to guide us in our mission to improve the quality of health care for all Americans.

