16% and 31% of respondents had indicated some improvements in the 3 trimesters of 2001 with regard to waiting time, kindness from physicians and nurses, kindness from administrative personnel, supply of drugs, conditions of facilities, and availability of medical equipment.

The undersecretary plans to address additional indicators related to prenatal care, management of diabetes in primary care, management of diarrhea in children under 5 years of age in primary care, management of respiratory infections in children under 5 years of age in primary care, delivery care, and hospital infection rate.

Although quality and satisfaction are low in some instances, they are improving. A long period of time will be needed to make the necessary improvements and restore the confidence of the population. The crusade is an important step in this direction.

1. Fundación Mexicana para la Salud. Population Satisfaction National Survey, 1994.
2. FUNSALUD. Public opinion about health care services in Mexico, August 2000.

Invited commentaries

Shared border, shared challenges

Enrique Ruelas, MD, Undersecretary for Innovation and Quality for Mexico, describes Mexico's efforts to address challenges in quality of care. Noting at the outset that Mexico spends a significantly lower percentage of its gross domestic product on health care, he presents an overview of the crusade for quality. The crusade, a partnership between the public and private sectors, is systematically taking steps to identify and address problems in quality identified by patients and providers. As Mexico's northern neighbor, the USA also confronts comparable challenges, despite spending a substantially higher proportion of its gross domestic product on the health care sector. This commentary reviews current efforts to address strikingly similar problems to the north.

US HEALTH CARE

Health care delivery is provided by a mix of public and private financing, although the delivery of services is largely, but not exclusively, private. Approximately 16% of Americans have no insurance, and equity also represents a critical challenge: a recent report from the Institute of Medicine confirms the existence and extent of disparities in health care associated with race and ethnicity (1). These findings are particularly disturbing in the face of an increasingly diverse population. Dissatisfied with pressures to limit time with patients, some physicians and health care systems have established special programs for individuals willing and able to pay more for more attention. "Boutique" or "concierge" medicine has inspired extensive debates within the profession and may further exacerbate current inequities (2).

THE QUALITY CHALLENGE: CURRENT RESPONSES

Joint efforts between the public and private sectors to assess and improve health care quality, such as assessment of clinical performance by states and through accreditation of health plans (3), have resulted in steady, albeit incremental, improvements. However, results of numerous surveys indicate that Americans perceive ample opportunities for improving health care quality. These beliefs have been corroborated by a stunning Institute of Medicine report published in 2001 that describes not a gap but a "chasm" between the quality of care that could be provided to Americans and that which is provided (4).

The Agency for Healthcare Research and Quality (AHRQ), a division of the US Department of Health and Human Services, is charged with leading federal efforts to assess and improve quality of care. In late 1999, AHRQ received a congressional mandate to produce annual reports to the nation on health care quality and prevailing disparities in health care delivery. The National Healthcare Quality Report (NHQR) will include a broad set of performance measures that will be used to monitor the nation's progress toward improved health care quality. The National Healthcare Disparities Report (NHDR) will describe disparities in health care associated with race, ethnicity, gender, age, income, geography, and the existence of disability and chronic illness. Both reports are intended to serve a number of purposes, such as 1) demonstrating the validity of concerns regarding quality and disparities in health care; 2) documenting whether quality and disparities in care are stable, improving, or declining over time; and 3) providing national benchmarks against which specific states, health plans, and providers can compare their performance. The first reports are due to congress in fiscal year 2003 and annually thereafter.

AHRQ commissioned studies by the Institute of Medicine to work on a conceptual framework for the NHQR and NHDR. Comprised of national leaders in the fields, both committees have heard testimony from a wide variety of groups, including the National Forum for Healthcare Quality Measurement and Reporting, Foundation for Accountability, National Committee for Quality Assurance, Joint Commission on Accreditation of Healthcare Organizations, leading academic researchers, international experts, and the public. The NHRQ committee has completed its work and recommended a conceptual framework that includes both dimensions of care (e.g., safety, effectiveness, patient centeredness, timeliness, equity) and patient needs (e.g., staying healthy, getting better, living with illness or disability, coping with the end of life) (5). The NHDR committee is ex-

pected to present its report shortly. Since disparities in health care represent a critical opportunity for quality improvement, the 2 reports will be closely linked, particularly since equity has been explicitly recognized as a key dimension of the NHQR. The need for reliable and valid data has prompted enhancements to AHRQ's data development that will provide unprecedented overviews of health care quality and disparities.

FROM MEASUREMENT TO IMPROVEMENT

The opportunity to provide a comprehensive and clear annual overview of health care quality and disparities is only an initial step in attaining requisite improvements in health care delivery. The results of AHRQ's research investments that examine strategies for translating evidence-based care into practice to improve quality and reduce disparities will provide an essential link to these annual reports. Over time, we anticipate that the reports will stimulate local and regional improvement efforts that will add to the evidence base for defining "best practices" that can be broadly replicated. In short, the reports must provide a springboard for action.

Such initiatives will add to the recognition that quality challenges are not delimited by geopolitical boundaries and that expanding the science of improvement represents a shared challenge and opportunity. The USA and Mexico thus share more than a common geographic border.

In the fall of 2003, AHRQ and the Academy for Health Services Research and Health Policy will jointly host the fifth biannual conference, the Internal Conference on the Scientific Basis of Health Services. (For information on this conference, see www.ahsrhp.org) Through this conference and other cross-national activities, we look forward to multiple opportunities for shared learning. In particular, we look forward to working closely with our southern neighbors to improve health care on both sides of our common border.

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5. Hurtado MP, Swift EK, Corrigan JM, eds. *Envisioning the National Health Care Quality Report. Committee on the National Quality Report on Health Care Delivery, Board on Health Care Services*. Washington, DC: National Academy Press, 2000.

Health care quality improvement through social participation

Dr. Enrique Ruelas' article, "Health care quality improvement in Mexico," reviews the Mexican government's National Health Program, which was developed to address the leading challenges facing their health care system, namely, equity between the rich and poor, financial protection for consumers from catastrophic care expenses, and quality in health care delivery. Although the National Health Program has 4 objectives, with corresponding strategies, the centerpiece of the effort is the National Crusade for Quality in Health Care. The crusade's general objectives are to improve the quality of health care, decrease variations throughout the system, and improve perceptions of the health care system. This aggressive campaign relies on collaboration between private and public entities and promotes the concept of joint ownership so that the crusade will develop momentum regardless of government support.

The National Health Program described by Dr. Ruelas is a welcome addition to discussions related to quality improvement that are currently occurring in the USA. The challenges facing the US health care system are surprisingly similar to those found in Mexico and are described in a report from the Committee on Quality of Health Care in America, Institute of Medicine (1). The report documents the need for the US health care delivery system to be more attentive to equity, in addition to improving safety, timeliness, patient centeredness, efficiency, and effectiveness. Similar to the situation in Mexico described by Dr. Ruelas, the quality of care delivered in the USA varies, depending on a patient's personal characteristics such as race, ethnicity, and socioeconomic status (SES). Generally speaking, members of racial and ethnic minorities and those of lower SES are more likely to experience poorer health outcomes compared with those of members of other demographic groups.

Studies from as far back as the Black report, published in 1982, demonstrate that health outcomes are related to SES, with lower levels of SES (e.g., low educational attainment and lower income) being associated with relatively poorer outcomes (2). Although access to care is a necessary component of improving health outcomes, it alone is not sufficient. Rather, health is dependent on multiple determinants and relies on an individual's unique biology, family history, social and physical environment, and behavior and lifestyle (3). Given the multidimensional character of health, solutions for improving the health of specific groups tend to transcend the more narrow focus of health care delivery, and cross over into political discussions of how to actually increase the SES or improve the quality of life of those who are at the greatest risk of poor health outcomes. Consequently, the outcomes of discussions about improving the health status of vulnerable populations frequently depend more on political philosophy than they do on what may be reasonable from a medical or public health perspective.

One of the most pressing issues related to equity in health outcomes in the USA concerns the challenge of how to best provide care to the country's estimated 40 million uninsured adults. A project being pilot tested in Dallas, Texas, is evaluating the effectiveness of a community collaborative of volunteer