

make better information available to health care decisionmakers to use to improve health care. AHRQ will help close the numerous data gaps throughout the health care delivery system. It will also serve as a bridge between the best science in the world with the best health care in the world.

The AHRQ will build on the foundation of strong scientific approaches to health services research established by the Agency for Health Care Policy and Research. This legislation was passed on an overwhelmingly bipartisan basis by the Congress, which is a tribute to the many members of both chambers, from both sides of the aisle. I particularly want to single out Senators Frist and Kennedy and Congressmen Bliley, Dingell, Bilirakis, and Brown, who have championed quality information for quality health care, for their commitment to this important reauthorization.

The AHRQ is now designated the lead Federal agency in health care quality to help meet the needs of decisionmakers and work in partnership with the private sector. AHRQ will de-

velop a national report on quality, stimulate evidence-based medicine, sponsor primary care research, help eliminate medical errors, and apply the power of information systems and technology in a manner that assures adequate patient privacy protections. AHRQ will also be a principal source of research that will guide health plans, purchasers, health care systems, clinicians, and policymakers as they seek to improve access to health care and make it affordable for all Americans.

I am delighted to sign S. 580, which will support research needed to improve health care and help train new pediatricians and pediatric sub-specialists who will be able to put this knowledge to work for America's children.

WILLIAM J. CLINTON

The White House,
December 6, 1999.

NOTE: S. 580, approved December 6, was assigned Public Law No. 106-129.

Remarks on Improving Health Care Quality and Ensuring Patient Safety and an Exchange With Reporters

December 7, 1999

The President. Good morning, everyone. I'd like to thank Secretary Herman, Janice Lachance, and the other representatives of the Federal Government who are here. I'd like to thank the leaders representing consumers, health care providers, business, labor, and quality experts who are here. This is a very impressive group of Americans who have come together to discuss the question of reducing medical errors.

Last week the Institute of Medicine released a disturbing report about patient safety and medical errors in our Nation's health care system. According to the study, as many as 98,000 Americans lose their lives each year as a result of preventable medical errors. Up to 7,000 die because of errors in prescribing medicine. And the cost of all these errors add as much as \$29 billion to our medical bills.

But this is about far more than dollars or statistics. It's about the toll that such errors take

on people's lives and on their faith in our health care system. We just had a terrific meeting this morning to talk about what we can do to save lives, to prevent errors, to promote patient safety. We have the finest health care system in the world, the best professionals to deliver that care. But too many families have been the victims of medical errors that are avoidable, mistakes that are preventable, tragedies, therefore, that are unacceptable.

Everyone here agrees that our health care system does wonders but first must do no harm. Now let me be clear about one thing: Ensuring patient safety is not about fixing blame; it's about fixing problems in an increasingly complex system, about creating a culture of safety and an environment where medical errors are not tolerated. In short, it's about working together to zero in on patient safety and zero out preventable errors. This morning's meeting builds

on our administration's longstanding record to improve health care quality.

Almost 3 years ago, I established the Commission on Consumer Protection and Quality Care, chaired by Secretary Shalala and Secretary Herman. That Commission produced a landmark report and led to my own executive action to provide patient protections to one out of every three Americans enrolled in Federal health care plans. It also set the stage for the Congress to pass a strong, enforceable Patients' Bill of Rights.

But the Commission has made clear that the challenge goes beyond patient protections for all Americans in all plans. We must also improve the quality of care. That's why I created an interagency task force to coordinate administration efforts in this area; why I asked the Vice President to launch the quality forum—and I thank Dr. Ken Kizer for being here today—a private advisory panel to develop uniform quality standards so that health plans compete on quality and not just cost, and consumers and businesses have better tools to judge what plans are best for them.

In a few moments, I'll announce new steps our administration is taking to promote quality and to reduce medical errors. But first, I want to turn it over to one of our partners in that effort. If there is one thing we have learned, it's that effectively managing the prescribing and dispensing of drugs is one of the best ways we can improve quality and hold down cost. The president of the American Hospital Association, Dick Davidson, is here this morning to announce a major new medical safety campaign they're launching with the Institution for Safe Medication Practices. It's truly a prescription for better health for all Americans. So I'd like to ask Dick to tell you about it.

[At this point, American Hospital Association President Richard J. Davidson made brief remarks.]

The President. Thank you very much, Dick.

I also want to just take a moment out here to thank Dr. Bill Richardson of the Kellogg Foundation for the Institute of Medicine report, and all those others who worked with him on it. It was a terrific document.

Now, let's talk about what we can do at the Federal level. First, I'm signing an executive memorandum this morning directing our health care quality task force to analyze the Institute

of Medicine study and to report back to me, through the Vice President, within 60 days about the ways we can implement their recommendations.

I'm also calling on the task force to evaluate the extent to which medical errors are caused by misuse of medications and medical devices and to develop additional strategies to reduce these errors.

Second, I want the Federal Government to lead by example. So I'm instructing the Government agencies that administer health plans for 85 million Americans to take an inventory of the good ideas out there now to reduce medical errors. They should apply those techniques to the health programs they administer and do so in a way that protects patient privacy.

As a first step, I'm announcing today that each of the more than 300 private health plans participating in the Federal Employee Health Benefits Program now will be required to institute quality improvement and patient safety initiatives. And I want to thank Janice Lachance, the head of our Office of Personnel Management, who had responsibility for figuring out how we were going to do this in record time. [Laughter]

Third, ongoing research to enhance patient safety, to reduce patient errors, is absolutely critical. So we're increasing our investment in this area. Yesterday I signed legislation reauthorizing the Agency for Health Care Quality and Research in providing \$25 million for research to improve health care quality and prevent medical errors. Through the work of the agency, we're also engaging our partners at the State level.

In March we'll convene the first national conference with State health officials to promote best practices in preventing medical errors. And I want to thank Dr. John Eisenberg for his leadership of that agency.

Finally, I'm directing my budget and health care teams to develop quality and patient safety initiatives for next year's budget so that we can ensure we're doing all we can to combat this problem. I want next year's budget to provide the largest investment to eliminate medical errors, improve quality, and enhance patient safety we've ever offered.

The Institute of Medicine's report makes clear that a systematic approach to reducing medical errors gives us the best chance of success. Years ago, we took that approach in aviation, and

we've dramatically reduced errors and saved lives. By working together, we can achieve the same goals in the health care industry. The American people deserve this, and we intend to provide it.

I am committed to working with all these people in partnership to do our part to save lives in needless medical errors, to make the best health care system in the world even better in the new century.

Thank you very much.

Q. Mr. President, many Americans, I would venture to say, were shocked, probably, to hear about this report, to learn that tens of thousands of people die each year, and tens of thousands more are injured because of medical errors. Does it call into question whether or not we have the best health care system in the world?

The President. No, I don't think it does. I think what it calls into question is whether we've done everything we can to invest the kind of money in avoiding errors that other big complex systems have.

I mentioned aviation, but I might also point out workplace safety. We have a representative from General Motors here who talked about how dramatically they have reduced injury in the workplace. Or if I could use an analogy that I think is, in some ways, even more appropriate, in the 1980's, when the American manufacturing sector was under withering competition from overseas and burdened by our big debt and high interest rates, they underwent the most disciplined imaginable review of every single process in every complex manufacturing operation to go to a zero-error rate.

If you look at the medical profession, if you look at the way hospitals work, if you think—Dick said tens of millions of people—I'm sure there are hundreds of millions of hospital visits every year—just to take hospitals. There are many people who are older who are taking multiple medications, who go to multiple doctors, so that what happens is, you've got a very complex set of processes that, as we have gotten to live longer, have become more complex and even more interactions. And what we need to do is to take—step back and take a critical look at each and every step along the way.

There have been big changes in the roles that various people in the health care system play. Have they all been properly trained to play that role? Do they all check with each other? Are there the right kind of teams in

place in every health care setting that work for safety? These are the kinds of questions that we have invested more money and time and research in, in the workplace and when we fly on airplanes, than we have in the health care arena. And we just have to do that now.

The good news about this is, this is something we can do something about. But if you ask me, does it mean we don't have the best health care system in the world, I would say, no, it doesn't mean that. Keep in mind, the life expectancy now is, what, over 76 years; anybody who lives to be 65 in America has a life expectancy in excess of 82 years. And when we finish the mapping of the human genome, I think sometime early in the next century, we'll look at babies being born that have a life expectancy of nearly 100 years.

So I think that this is just a problem that—I applaud the lack of defensiveness that all the players in the health care system have displayed here. I applaud the report. And we know what the dimensions of this problem are, and now we've got the people in place with the determination to solve it. And I think that we ought to look at this as a very positive event in the progress of American health care.

Elia Gonzalez

Q. Mr. President—[inaudible]—to President Castro's threats of retaliation against the U.S. unless that Cuban boy is returned?

The President. I will do a press conference tomorrow, and I'll answer all those other questions. I'm looking forward to it.

Health Care Quality

Q. Speaking of lack of defensiveness, should the White House have spotted this problem of medical errors sooner and taken action sooner? And also, isn't this a problem, now, for hospitals and other medical providers, because if they take action to remedy past mistakes, they admit past mistakes, and couldn't they be open to lawsuits?

The President. Well, first of all, I think there has been a lot of work on this over the last 3 years. But I don't think there's any question that the Institute of Medicine report, with its actual calculation of the numbers of lives lost, has focused everybody's attention more on this, including me. And I think the only productive thing to do is to look forward now.

Secondly, when this report came out, I learned that 22 States—if you look at what the report recommends, it recommends mandatory reporting of serious mistakes and errors, and 22 States have that in place and presumably don't have any more significant lawsuit or medical malpractice problems than the rest of the country as a whole.

And regardless—you know, once you know about a problem, you're under a moral obligation to deal with it. So you can't—whatever the consequences are, we have to go forward.

Finally, I do not believe that the kind of systematic improvement in safety training and processes, hospital after hospital after hospital, clinic after clinic after clinic, and in outpatient settings, will increase liability. No one can begrudge the improvement of processes. That still won't establish or fail to establish liability in a particular case. So I don't see that as a problem.

But whatever the problems are, they're not nearly as important as saving thousands and thousands of lives that obviously are there to

be saved now. And that's what all these people behind us are saying. And I think they reflect the overwhelming views of doctors, hospitals, nurses, and everybody else in the health care system.

So this is a good day for America, not only because of this report but because of the response to this report.

Thank you very much, and I'll see you tomorrow.

NOTE: The President spoke at 11:45 a.m. in the Rose Garden at the White House. In his remarks, he referred to Dr. Kenneth W. Kizer, M.D., president and chief executive officer, National Quality Forum; W.K. Kellogg Foundation president and chief executive officer William Richardson, chair, Institute of Medicine Committee on Quality of Health Care in America; and Bruce E. Bradley, director of managed care plans, General Motors. The transcript released by the Office of the Press Secretary also included the remarks of Mr. Davidson.

Memorandum on Improving Health Care Quality and Ensuring Patient Safety

December 7, 1999

Memorandum for the Secretary of Defense, the Secretary of Labor, the Secretary of Health and Human Services, the Secretary of Veterans Affairs, the Director of the Office of Personnel Management

Subject: Improving Health Care Quality and Ensuring Patient Safety: Directive to the Quality Interagency Coordination Task Force (QuIC)

Assuring quality through patient protections is a long-standing priority for my Administration. Over the past 2 years, with the leadership of the Vice President, Secretary Shalala, and Secretary Herman, my Advisory Commission on Consumer Protection and Quality in the Health Care Industry (Quality Commission) produced a landmark report on health care quality. Through executive action, I extended the patient protection provisions outlined in this report to the 85 million Americans enrolled in Federal health plans, setting the stage for the Congress

to pass a strong, enforceable Patients' Bill of Rights. As important as putting patient protections in place, however, is improving the quality of the services available to these patients.

The United States has some of the finest medical institutions and best trained health care professionals in the world. However, as the Quality Commission reported last year, millions of Americans are harmed or even killed each year as a result of inappropriate or erroneous medical treatment. These health care quality problems include the underutilization of needed services, the overutilization of unnecessary services, and medical errors in the delivery of care. In addition, there is a continuing pattern of wide variation in health care practice.

As a recent Institute of Medicine study confirms, preventable medical errors present an example of the critical importance of improving the quality of health care in our Nation. Over half of the adverse medical events that occur