

AFR NATIONAL HEALTH CONFERENCE

HEALTH CARE REFORM IN THE US AND AUSTRALIA

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It used to be that we looked at the US only as an example of how not to do health care. But increasingly there are things for Australia to learn from the US in terms of doing health care well, and this paper addresses two of these issues.

The first is about health care reform – real and complete reform, not just more money in play to go on doing more of the same things. The second is about making the health care system sustainable into the future, more focused on health outcomes, and improving quality and safety – all at the same time.

The path to the day in March that President Obama signed the Patient Protection and Affordable Care Act (PPACA) into law was long and tortuous – a series of disasters, missteps, political manoeuvres, lucky moments and persistent hard work and commitment.

I. THE SHAPE AND SCOPE OF HEALTH CARE REFORM IN THE US.

What's in the health care reform bill – the Patient Protection and Affordable Care Act (PPCA)

1. Coverage and affordability.

- Extends coverage to 32 million Americans who are currently uninsured (95% of people legally in the US).
- A patchwork achieved by :
 - Extending Medicaid for people up to 133% of Federal Poverty Level (\$29,327 pa for a family of 4).
 - Providing subsidies to help people between 133- 400% of FPL (\$88,200 pa for a family of 4) to purchase health insurance on state-based exchanges, which will offer a competitive market place.
 - Providing subsidies to small business to help them purchase health insurance for employees on state-based exchanges.
 - Requiring larger businesses to provide cover to employees.

2. Universal mandate

- Mandate on larger employers and individuals to have health cover is essential to ensure affordability and protect against cost-shifting.

3. **Health insurance reforms**

- Most important of these is the provision that bans exclusions based on pre-existing conditions.
- Premiums may only vary by age (up to 3x), tobacco use (1.5x) and geographic rating.
- No rescission of cover on basis of health status or use.
- Prohibit excessive waiting periods.
- Limit annual out-of-pocket costs to \$5,950 per individual and \$11,900 per family, (indexed).
- Must cover individuals participating in clinical trials.
- No lifetime or annual limits on cover.
- Patients have right to choose a doctor and receive cover for emergency services without prior authorization.
- Dependent children up to age 26 can stay on parents' policy.
- Large group plans must spend 85% of premiums on clinical services and other activities for the quality of care for enrollees. Small group and individual market plans must devote 80% of premiums to these purposes.
- All insurance plans sold after 2014 must include a basic package of benefits including hospitalization, outpatient services, maternity care, prescription drugs, pediatric oral care, emergency care and preventive services.
- No co-payments or cost-sharing for preventive health benefits.

4. **Investments of \$26 billion in prevention, primary care, public health and workforce.**

This includes \$11 billion for community health centres. On a population basis the equivalent Australian investment would need to be \$2.5 billion / 10 years.

Provisions include:

- Medicare will provide seniors with free annual wellness visits and personalized prevention plan services.
- Medicaid will provide coverage for comprehensive tobacco cessation services for pregnant women and incentives to beneficiaries who successfully complete certain healthy lifestyle programs targeting chronic disease risk factors such as high blood pressure, high cholesterol, and diabetes.
- Establishment of a National Prevention, Health Promotion, and Public Health Council to provide leadership on an expanded and sustained national investment in prevention and public health programs and direct the creation of a national prevention and health promotion strategy.
- Development and operation of school-based health clinics and nurse-managed health clinics to provide comprehensive and accessible preventive and primary health care services to medically underserved children and families.
- Funding for community-based preventions and wellness programs that promote individual and community health by reducing chronic disease rates, addressing health disparities, and developing a strong evidence-base of effective prevention programming.
- Community transformation grants that focus on healthier school environments, active living communities, and access to nutritious foods.
- Programs to support workforce education and training and provide funding to expand primary care capacity for a range of primary care professionals. There are provisions to encourage workforce diversity and to ensure cultural competency.
 - Establishment of a National Health Care Workforce Commission to maintain a well-distributed, balanced workforce that meets local and national needs.
 - Support for innovation in primary care practice.

- Expands National Health Service Corps, and establishes a Public Health Sciences Track and a Public Health Services Ready Reserve Corps.

5. Long-term care

- Nursing home transparency and enforcement provisions, including a ‘nursing home compare’ website.
- Dementia and abuse training requirements for nursing home staff.
- Community Living Assistance Services and Support (CLASS) Act establishes a national voluntary long-term care insurance program for actively employed individuals through a payroll deduction system. The program will pay a sliding scale cash benefit averaging \$50 a day that can be used to purchase typical home and community based long-term care assistance, and other non-medical services. The actual daily benefit amount an individual receives will be based on an assessment of the functional limitations of a covered individual.
- Pain management is recognised as a national public health problem, and a Pain Consortium is set up at NIH to enhance pain research and promote collaboration among researchers across various NIH Institutes. A program is established to train health professionals in pain care management.
- Incorporates the Elder Justice Act – comprehensive federal legislation to address abuse, neglect, and exploitation of the elderly at the federal level.

6. Quality and safety, addressing disparities, data collection.

- PPACA specifically leverages several broad mechanisms to improve the quality of health care:
 - Requires a national strategy for healthcare quality improvement, quality measurement and the use of quality data.
 - Incentives for the development or implementation of, or facilitating, a number of health service delivery reforms (such as care coordination).
 - Targeting quality improvement reforms across the spectrum of payers, including private health insurers, Medicare and Medicaid.
 - Support for the development of evidence-based care practices and clinical guidelines.
- Elevates the existing Office of Minority Health in the Office of Public Health and Science at the Department of Health and Human Services (HHS) by placing it within the Office of the Secretary.
- Designates the NIH National Center on Minority Health and Health Disparities as an Institute.
- PPACA includes three sets of provisions that aim to enhance the completeness, accuracy, and uniformity of health data.
 - Mandates the collection and reporting of data on race, ethnicity, sex, primary language, and disability status by all federally conducted and supported health care and public health programs, activities, and surveys.
 - Requires the development of a system to collect data on key national indicators.
 - Seeks to improve states’ collection of vital statistics by educating providers about the importance of standardized birth and death certificate data.

7. Making the system sustainable into the future

- Reduces the budget deficit by \$143 billion over the first decade.
- Extends the life of the Medicare trust fund by 12 years.

- ‘Bending the curve’ – making savings by:
 - Tackling fraud and abuse and waste in Medicare.
 - Innovation.
 - Comparative effectiveness research.
- Patient literacy and decision making.
- Facilitating biomedical and translational research for new cures and treatments.

8. Funding provisions

- PPACA costs \$800 billion / 10 years.
- This is paid for by:
 - \$500 billion in savings from Medicare in waste, fraud and abuse.
 - a tax on ‘cadillac’ health insurance plans.
 - levies on the health insurance, pharmaceutical industry and medical device industries.
 - a tax on tanning salons.

Other provisions that are important were enacted elsewhere:

State Children’s Health Insurance Program (S-CHIP)

One of the first bills signed into law by President Obama was a \$33 billion bill that will expand the S-CHIP program to cover an additional 4 million mostly low-income children, bringing the number covered by the program to 11 million. The measure is funded primarily by boosting the federal tax on cigarettes by 61 cents, to \$1 a pack.

E-health

The American Recovery and Reinvestment Act (ARRA), signed by President Barack Obama on February 17, 2009, allocates approximately \$36 billion to health information technology projects. ARRA includes two major components that have an impact on health IT.

- Medicare and Medicaid incentives (\$34 billion) – The incentives and penalties provided through Medicare and Medicaid reimbursement are designed to help physicians and hospitals acquire electronic health record (EHR) technology. In order to receive these new and significant incentives, physicians and hospitals will have to prove “meaningful use” of their “certified” EHRs.
- Health Information Technology for Economic and Clinical Health (HITECH) Act (\$2 billion) – The HITECH Act formally establishes the Office of the National Coordinator (ONC). The ONC will use these funds to promote a nationwide health IT infrastructure, to facilitate the creation and dissemination of health IT policies and standards, and to create regional health IT extension centers (RHITECs). RHITECs will support physicians and hospitals in the implementation and adoption of health information technology.

Comparative effectiveness research

- ARRA contains \$1.1 billion for comparative effectiveness research at the National Institutes of Health (NIH) and the Agency for Health Care Quality and Research (AHQR). The Institute of Medicine (IoM) was required to develop priorities for this work.

Community Health Centers

- ARRA provides \$2 billion to be invested in Community Health Centers.

Mental health parity for Medicare and private insurance

- The Mental Health Parity and Addiction Equity Act of 2008, signed into law by President Bush but not effective until 2010, prohibits insurers from charging more for mental services than other services.
- Under the Medicare Improvement for Patients and Providers Act of 2008, Medicare coinsurance for mental health services will be gradually reduced over the next five years until in 2014 they are 20%, the same as for most other services.

NIH funding for biomedical research

- In return for providing one of only three Republican votes in the Senate for the Obama administration's \$787 billion economic stimulus package, Senator Arlen Specter was able to secure a 34% increase in the NIH budget - to \$39 billion from \$29 billion.
- Nearly \$2 billion is intended for building and equipment projects at the NIH and universities across the country. Most of the money will go to pay for as many as 15,000 additional grants submitted by research scientists.

Regulation of Tobacco

In June 2009 the Congress passed and the Senate signed into law the Family Smoking Prevention and Tobacco Control Act, which gives the Food and Drug Administration authority to regulate the content, marketing and advertising of cigarettes and other tobacco products.

Veterans' health

In May 2010 President Obama signed into law the Caregivers and Veterans Omnibus Health Services Act which will:

- Ensure that families of veterans severely wounded in Iraq and Afghanistan receive comprehensive, coordinated financial and other support that will enable them to provide home care for severely disabled veterans.
- Expand mental health and counseling services to veterans of the wars in Iraq and Afghanistan, including National Guardsmen and reservists.
Allow the Veterans Administration to use hospitals outside the VA network to treat more returning soldiers suffering from brain injuries.
- Eliminate co-payments for "catastrophically disabled" veterans.
- Increase housing and transportation assistance for veterans living far from hospitals in rural areas.
- Expand health care services for women veterans, including maternity care for newborns.
Begin a pilot child-care program for veterans receiving intensive medical care.
- Expand support for homeless veterans.

Obesity

- The First Lady has launched a nationwide campaign called "Let's Move" to tackle childhood obesity. The campaign has four pillars: Getting parents more informed about nutrition and exercise, improving the quality of food in schools, making healthy foods more affordable and accessible for families, and focusing more on physical education.
- This is accompanied by a federal task force to provide optimal coordination between private sector companies, not-for-profits, agencies within the government and other organizations to address the problem of childhood obesity.

HIV /AIDS national strategy

In July the White House unveiled a new national HIV/AIDS strategy.

Other legislation that is underway

Children's nutrition

Congress is working on reauthorization of the Child Nutrition Act, the major federal legislation that determines school food policy and resources. The Senate passed version of the bill will commit an additional \$4.5 billion to child nutrition programs over the next 10 years. It would set new nutritional and safety standards for all food served in schools.

Food safety

The Congress is considering the Food Safety Modernization Act which would provide the FDA with increase^{3d} food inspection authorities to prevent food contamination.

The drivers for health care reform

It's useful also to look quickly at what the factors were that helped Obama and the Democrats get health care reform enacted.

- The system was broken – and everyone recognized that. The debate was over what to do about it, and the role of the federal government.
- Health care providers were on- side and supportive. Not just doctors and nurses, but hospitals.
- Not the Clinton approach. Obama was criticized for standing back, but it was necessary for the Congress to own the bill. The president provided outlines but not details.
- Health care as important to America's economic competitiveness, not as a social justice issue.
- Writings of people like Atul Gawande and research from the Dartmouth Atlas of Health Care that highlighted that a renewed focus on quality and safety could save money.
- Democrat leaders were willing to lead and to fight to get this done.

II. INNOVATION IN HEALTH CARE FUNDING AND DELIVERY

There are several key elements to health care reform that taken together will change the shape of health care funding and delivery in the future. It is important to note that US health care providers are almost universal in their support of these approaches. Three other issues are important here – the role of health IT, the focus on using data to improve health care disparities and quality and safety, and the recognition that patients need to be more involved in decision-making and managing their treatment.

Comparative effectiveness research

Comparative effectiveness research (CER) compares treatments and strategies to improve health, providing information that is essential for clinicians and patients to decide on the best treatment. It also provides a means of measuring the performance of the health system and addressing health care disparities.

Also a very sensitive issue – the naysayers around health care reform see it as a means of rationing health care. Conservatives have cited many stories (mostly false) about the UK National Institute for Clinical Effectiveness (NICE) and how it works – for example claiming that Senator Kennedy would not have received treatment for his brain tumour in the UK.

Perhaps for this reason, the final version of the bill abandoned use of the term ‘comparative effectiveness’ and the legislative language now talks about ‘patients centred outcomes research’.

Patient-Centered Outcomes Research Institute

The new law establishes a Patient-Centered Outcomes Research Institute (PCORI) as a nonprofit corporation that is not “an agency or establishment of the U.S. Government.”

The purpose of the Institute is “to assist patients, clinicians, purchasers, and policy-makers in making informed health decisions by advancing the quality and relevance of evidence concerning the manner in which diseases, disorders, and other health conditions can effectively and appropriately be prevented, diagnosed, treated, monitored, and managed through research and evidence synthesis that considers variations in patient subpopulations, and the dissemination of research findings with respect to the relative health outcomes, clinical effectiveness, and appropriateness of medical treatments, services, and items.”

It will do this through efforts that:

- Conduct, support, or synthesize research that compares the clinical outcomes, effectiveness, and appropriateness of items, services, and procedures that are used to prevent, diagnose, or treat diseases, disorders, and other health conditions.
- Encourage the development and use of clinical registries, clinical data networks, and other forms of electronic health data that can be used to generate or obtain outcomes data.

The specific duties of the Institute are to:

- Establish an objective research agenda;
- Develop research methodological standards;
- Contract with eligible entities to conduct the research;
- Ensure transparency by requesting public input; and
- Disseminate the results to patients and healthcare providers.

The Institute will have a 21-member Board of Governors, including the Directors of the Agency for Healthcare Research and Quality (AHRQ) and the National Institutes of Health (NIH).

A variety of entities are eligible to receive funding contracts, including federal agencies, academic institutions, and private research organizations. The Agency for Health care Research and Quality and the National Institutes of Health will receive priority funding consideration. Data collected by the Center for Medicare and Medicaid Services will be made available to contracting research groups, and the Institute may request data from other federal, state, and

private entities hosting patient registries and other databases. The Institute will emulate the peer-review processes of the NIH and AHRQ.

A standing methodology committee will lead efforts to identify and refine methodological standards for different types of CER study designs, such as pragmatic clinical trials, randomized controlled trials, and patient registries.

The Institute will form a number of internal advisory panels to set research priorities and oversee clinical trials. These panels will include practicing clinicians, patient and consumer representatives, clinical and health services researchers, payers, manufacturers, and others. The health reform bill requires the Institute to provide patients and consumers with the extra support, tools, and resources necessary to be effective members of these advisory panels. In addition, there will be public comment periods to allow the general public to provide feedback to the Institute on proposed priorities and other key decisions, in an effort to make the work of the Institute and advisory panels as transparent as possible.

The law allows CMS to use CER evidence in coverage and/or reimbursement decisions as long as the coverage process is an iterative one—a standard that the current CMS national coverage determination process meets. CMS may also use CER to establish differential copayments, which could be used in a value-based insurance design program. The bill specifically prohibits any cost-effectiveness analysis that would use any adjusted life years factor that would place lower value on the life of elderly, disabled, or terminally ill individuals compared to younger and healthier individuals.

Research findings must be released to the general public no later than 90 days after they are available. The Office of Communications and Knowledge Transfer at AHRQ will facilitate the wide dissemination of findings, with assistance from NIH. This will include consultation with medical and clinical associations to ensure that findings are translated into clinical decision support tools.

The Institute will be funded through the Patient-Centered Outcomes Research Trust Fund (PCORTF), which will consist of funding streams from general revenues, an annual \$2 fee per Medicare beneficiary transferred from the Medicare Trust Fund, and an annual \$2 fee per-covered-life assessed on private health plans. The Medicare Trust Fund transfer and annual fee on insured and self-insured plans does not take effect until 2013. By 2015, total annual funding for the Institute will reach nearly \$500 million.

Center for Innovation in Medicare and Medicaid

One of the most important provisions is the creation of a new center within the Center for Medicare and Medicaid Services (CMS) that would focus on payment innovation. This is a clear sign that Congress believes CMS – the funder of both Medicare and Medicaid - needs to have the flexibility to develop, implement and evaluate new payment models for services outside the traditional fee-for-service model. Currently the only way this innovation can be undertaken is under a waiver or in accordance with legislation that would specifically allow a new pilot or demonstration project that changes the way Medicaid or Medicare pays for services.

The legislation gives broad authority and funding to the Center for Innovation to determine what models will be tested, in what populations, and for how long, with a preference for models that reduce program costs while preserving or enhancing quality. To assure the focus is not only on

cost-cutting measures, there is a requirement for providers to report on outcome measures at the “patient-level.” There is also language that prioritizes models that work with private payers in addition to Medicaid and Medicare.

Another important point here is the provision that allows the Secretary (in consultation with CMS) to expand the duration and scope of successful models and terminate or modify models that do not work effectively. This is critical so that when a hospital or group of providers changes their practice to accommodate a new payment method, and this works, they will not need Congressional intervention to continue or expand the initial project. The need for congressional approval has delayed or derailed past initiatives, even when they have been shown to be successful.

Another critical issue is that the Center for Innovation would not have to require projects to be budget-neutral during their initial testing period. Many health care innovations require initial investments in staff, training, and infrastructure to achieve long-term efficiencies.

The new law includes a \$10 billion appropriation for the Center through 2019. This will allow the CMS, which has faced chronic shortages of administrative resources, to build the capacity necessary to manage the program effectively. It will also allow the Center to pay for services such as care coordination that aren’t covered by traditional Medicare and to support activities such as electronic data sharing, performance measurement, and quality improvement at participating health care systems.

Although pilot projects will not have much effect on national health care spending in the short run, they can encourage innovation in health care delivery by reducing or eliminating the link between service volume and provider revenue, and are expected to reduce outlays in the long-term.

New ways to deliver and pay for health care services

The US health care reform package has a raft of measures that will fund and expand these new models. Among them:

- financially rewarding primary care practices that provide care co-ordination programs using, for example, nurse care co-ordinators and home-based monitoring;
- bundling payments for entire treatment needs or cycles of care, rather than paying for individual visits or procedures, with rewards for the delivery of care that improves patient outcomes; and
- limiting payments for hospital readmissions that result from hospital-acquired infections and preventable errors.

The principle here is to fund quality, not quantity, and value, not volume.

Co-ordinated primary care

The US is starting from a different place than Australia. For example, Australia already has primary care as the recognised foundation of the health care system, and arguably most Australians have, through their GP, a medical home that helps co-ordinate their care – at least in theory.

Still the US has some interesting mechanisms for financially rewarding the delivery of primary care through approaches such as the ‘medical home’ and other care coordination programs. For example, the Massachusetts Coalition for Primary Care Reform has established a framework for medical homes, with payment methods including risk-adjusted per-patient-per-month payments as well as bonus payments for achieving outcomes in not just quality and cost-effectiveness but also patient satisfaction.

Initiatives to establish medical homes to provide coordinated care to people with mental illness and co-occurring primary care conditions and chronic diseases are clearly examples of initiatives that would be welcome in Australia.

The Geisinger Medical Home is a private health service that operates in Pennsylvania and offers round-the-clock access to primary and specialty care services for 2.5 million patients who are, on average, poorer, older, and sicker than patients nationally.

This medical home model provides nurse care coordinators, care management support, and home-based monitoring. Electronic health records aid physicians and patients in more efficient delivery of care. To encourage participation in the program, Geisinger provides monthly payments of \$1,800 per physician and stipends of \$5,000 per 1,000 Medicare patients to finance additional staff. An incentive pool is created based on differences between the expected and actual total cost of care for medical home enrollees. Incentive payments are conditional upon meeting certain quality indicators.

Despite the increased payments to physicians, preliminary data show 7 percent savings in total medical costs, in part due to a 20 percent reduction in hospital admissions and 29 percent reduction in emergency department visits. Participants in the case management program for patients hospitalized for heart failure had 32 percent fewer readmissions than those not in the program and 84 percent of patients in the program achieve stable or improved functional capacity.

It isn’t just that this care was funded and provided, it’s that the data were collected to highlight how effective it is. That’s not something that is routinely done in Australia.

Reinventing Community Health Centres

In the US one of the most successful ways to deliver a medical home and the raft of needed coordinated care services in medically underserved areas is through Community Health Centres. Community Health Centres are community-based and patient-directed organizations that provide health care to populations with limited access to health care. Today they serve over 20 million patients; with additional funding provided through ARRA and PPACA it is expected that they will be serving more than double this number of patients by 2015.

The statute that created these centres requires them to meet 4 basic standards:

- They must be located in or serve a high need community;
- They must provide healthcare to all, regardless of ability to pay;
- They must provide comprehensive health care services; and
- They must be governed by a community board.

Community Health Centres must provide a full range of health related services. This means in addition to providing comprehensive primary health care services, they also offer specialty care, dental and mental health services as well as supportive services such as nutrition education, case management, translation services, care coordination and case management, transportation to and from health care sites and outreach activities. This also means the care delivered is culturally appropriate and in languages that many in the community speaks.

There is excellent data to show that they deliver better services less expensively, eliminate unnecessary hospital visits, reduce health care disparities and deliver patient satisfaction.

But the benefits extend well beyond the doors of the clinic. Community Health Centres generate enormous economic activity in the broader community that also creates new jobs. Every dollar spent and every job created by health centers has a direct impact on their local economies.

Those with long memories might remember that the Whitlam Government pushed to establish Community Health Centres, in cooperation with state and local governments. So we might ask, at a time when the focus is on better coordination of state and federal governments in health care, ensuring affordable access to the range of needed services - especially prevention and care coordination, and providing services that are tailored to local needs, are we trying to re-invent the wheel, not very successfully, with GP SuperClinics?

The answer, I suspect, has much to do with lack of institutional memory and AMA opposition to any such plan – in the 1970s and today. And no-one has ever looked at the possibility of some version of GP SuperClinics to feed into the economies of the communities in which they are built.

It's a good bet that the AMA will find Community Health Centres as loathsome today as they did under Whitlam. But I suspect that the new generation of young health care professionals – doctors, nurses and others – might find the idea appealing both professionally and financially. And the Government could help drive this by stealing another Obama idea and establishing a National Health Service Corps to staff such health centres.

Bundled payments

The current health care delivery system is not well organized around the care needs of patients, which are rarely delivered in an isolated episode. The existing Medicare payment system rewards doctors for delivering more services rather than better care. Even where MBS items are directed at management plans for chronic illnesses or multidisciplinary care for cancer patients, the only measure of effectiveness is the number of such services delivered.

In the United States there is now a drive in both the public and private systems, largely supported by the full range of health care providers, to move away from fee-for-service to bundled-care payments for entire treatment needs or cycles of care, which may span multiple providers and settings.

In a speech last year to the American Medical Association, President Barack Obama urged an audience of doctors to get on board with bundled care. "You entered this profession to be healers," he said. "Now, that starts with reforming the way we compensate our providers - doctors and hospitals. We need to bundle payments so you aren't paid for every single treatment you offer a patient with a chronic condition like diabetes, but instead paid well for how you treat the overall disease."

At this point in time such an approach, aimed at encouraging better management of diabetes patients, has not been viewed favourably in Australia. However this is a particularly effective form of payment for the care delivered around an acute hospital episode and the post-acute or rehabilitation period, and there is evidence to support this effectiveness.

One example is ProvenCare, operated by Geisinger, a large, integrated private healthcare system in Pennsylvania. This program started an episode-based bundled payment structure for coronary artery bypass grafting and now also covers hip replacement and cataract surgery this way. It involves a global fee that covers the work-up, surgery, hospital and professional fees, and any additional work related to complications from the initial procedure. The ProvenCare program, in effect, offers a 90-day warranty on the surgery covered. If complications arise or the patient returns to the hospital within three months, Geisinger bears the additional cost.

By changing the reimbursement structure for bypass surgery, Geisinger actually changed the way care was delivered. Not only did the costs come down, but outcomes improved, due in large part to greater payer-provider collaboration and better organization of care. ProvenCare has increased the proportion of patients receiving all 40 required components for coronary artery bypass graft surgery from 59 percent to 100 percent. The percentage of patients discharged directly to home increased to 93 percent from 81 percent, and 30-day hospital readmissions dropped by 44 percent. Geisinger relies heavily on e-health records to make these improvements possible.

An Accountable Care Organization is a relatively new concept of health care delivery that is largely driven by changing how care is delivered and paid for. An ACO holds providers responsible for delivering comprehensive care to a designated group of patients. ACOs that achieve quality and cost targets receive a financial bonus. Financial penalties may also be incurred if targets are not met. The goal is to create an incentive for the ACO to constrain volume growth while improving the quality of care.

An Australian ACO model would offer the possibility of linking together Medicare Local and Local Hospital Networks. A typical ACO consists of primary care clinicians, specialists, and hospitals, including many individual practices. An ACO needs to be able to care for patients across the continuum of care in different institutional settings, plan prospectively for its budgets and resource needs, and support comprehensive, valid, and reliable measurement of its performance. This model of health care delivery also recognises that often what's needed is not medical care but help with managing travel to medical appointments, complicated medication regimes and out-of-pocket costs that limit patients' compliance with recommended treatment.

One example is the Camden Coalition of Healthcare Providers, which has operated for the past eight years in Camden, New Jersey. CCHP is a citywide organization whose activities focus on community outreach, care management of high-needs patients, health care provider education, practice management capacity building, data collection and evaluation, and coalition-building among key stakeholders.

CCHP has a multidisciplinary outreach team to provide care management to the highest users of Camden emergency departments and hospitals. This team includes a nurse practitioner, a bilingual medical assistant, and a social work case manager who conduct visits to homes, housing shelters, and even the streets to coordinate care in a patient-centered approach. The project provides transitional primary care, helps patients apply for Medicaid or other government sponsored benefits programs, coordinates specialty care, coordinates transportation, helps patients access medical day programs and other social services, and provides emotional support.

Evaluation after one year of operation indicated that patient utilization of ERs and hospitals decreased by 40 percent after enrolling with the project and health systems charges for the care of these high-utilizing patients was reduced by 56 percent.

We get what we pay for in healthcare. The current system rewards volume and intensity, paying for more services regardless of the value they provide – it's an approach that doesn't always keep people healthier. Changing the incentives by changing the reimbursement system so that it pays for value not volume provides enormous potential to improve patient health, slow the growth of medical costs, and deliver greater satisfaction to both doctors and their patients.

Tackling preventable errors

Checklist-type initiatives such as those driven by Peter Pronovost, an anesthesiologist at Johns Hopkins Hospital, Professor Donald Berwick, now head of the centers for Medicare and Medicaid Services, and Atul Gawande, a surgeon at Harvard, show how quickly and cheaply dramatic progress can be made in reducing hospital-acquired infections, saving lives and money.

A health care checklist is usually nothing more than a list of what every provider knows should be done for a given procedure. But just as a checklist ensures that pilots go through all the necessary steps when flying a plane, so can a checklist help health care workers correctly manage a complicated procedure in an environment where time is critical.

The Keystone Initiative in Michigan, which began in 2004, uses a series of checklists focusing specifically on preventing infections in intravenous lines and catheters. The program, involving 108 intensive care units, focuses on using checklists of evidence-based interventions and changing hospital culture, and was funded by the Department of Health and Human Services' Agency for Healthcare Research and Quality.

Physicians and nurses at the participating Michigan intensive care units implemented the following interventions:

- Routinely washing hands
- Using full sterile procedures when catheters are inserted into veins
- Cleaning the patient's skin with chlorhexidine, a long-lasting liquid antiseptic soap
- Avoiding the femoral site (groin area) for catheter insertion, when possible
- Removing unnecessary catheters

Within three months of implementing this simple set of interventions, Michigan ICUs slashed their bloodstream infection rates by 66 percent. The median infection rate dropped from 2.3 per 1,000 catheter days to near zero.

From 2004 to 2008, nearly 1,800 lives were saved and 129,000 extra days in the hospital were avoided due to this patient-safety initiative. Each hospital spent about US\$120,000 in staff time to implement the safety changes and estimated savings were over US\$200 million.

These impressive results have been sustained through to the present.

The Australian checklist approach

At Geelong Hospital, Dr Stephen Bolsin provided registrars with a portable, programmed, PDA device and asked them to report incidents that happen as they carry out their work in their very busy days. They can achieve 98 per cent reporting of the incidents occurring to those registrars - a very high level of reporting. About half of the incidents reported had no impact or a minor impact on patient outcomes. These may well be the "near miss" incidents that are the "holy grail" of healthcare safety experts

When it is made easy people will report these events. There is a technological imperative with a PDA: don't have to wait for them to get a piece of paper, find an address to write to, write the report, then photocopy it, then send a duplicate and so on. It can be done in a few seconds with drop-down menus on a screen. This is one way in which we can improve the medical and ethical education of trainee doctors.

These results were first reported in 2002. So far, however, there has been limited enthusiasm from health bureaucrats for implementing a PDA-based system for adverse event reporting.

CONCLUSION

All those committees and reports the Australian government commissioned were unanimous in their advice that the healthcare system of the 21st century must focus on prevention, better management of chronic illness and the co-ordination of care.

When these services are provided effectively, they can keep people - even the chronically ill and frail elderly - out of hospital, thus helping to address problems such as crowded emergency departments and the need for more hospital beds and staff.

It used to be that Australians looked at the US as an example of what health care should not be. Now, in terms of innovative ways to both develop and evaluate new health policies and deliver and fund health care, there are effective American models we could look to implement. Such models provide better outcomes at reduced cost.

Australia isn't bereft of such innovative approaches, although too many successful pilots have gone nowhere, victims of short-term funding and failure to capitalise on what has been learned.

The US healthcare reform legislation includes mechanisms for ensuring that innovation is a consistent driver, not just a series of isolated projects.

Despite the fact that it is not a single payor system, does not have a national public health insurance option, and has real restrictions on the coverage of abortion, what has happened in the US is real reform. It hits all the key bases.

Moreover, it is reform that is paid for, and that actually helps reduce the deficit out into the future.

The roll-out has already begun and is well ahead of schedule.

This stands in stark contrast to Australia where a lot of money and very few details have been put on the table, and there is little that counts as real reform. Unless there are changes in the implementation, what we will end up with will be more of the same, with the key focus still on

more hospital beds and more elective surgery, and the measure of success is activity and the number of services delivered, not improved health outcomes and patient satisfaction.

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