Editorials

Bringing it all back home: can Europeans learn from recent moves toward the medical home in US primary health care reform?

Aileen Clarke¹, Alan B. Cohen²

¹ Health Sciences Research Institute, Warwick Medical School, University of Warwick, Coventry, UK
² Boston University, Health Policy Institute, School of Management, Boston, MA, USA

Correspondence: Aileen Clarke, Professor of Public Health & Health Services Research, Health Sciences Research Institute, Warwick Medical School, University of Warwick, Coventry, CV4 7AL, UK. tel: +44 (0) 24 761 51060, fax: +44(0) 24765 28375, e-mail: aileen.clarke@warwick.ac.uk

As its health care system undergoes reform, most observers would agree that US primary care is fragmented and un-coordinated. Instead of being provided by a medical generalist in a context of continuity, it has traditionally been provided by specialists, particularly from internal medicine or pediatrics. This has been considered a major driver of rising costs in the US system. Minor conditions are seen through the lens of specialty-focused care, which can lead to over-testing and over-treatment by anxious specialists, untrained in the arts of laid-back watchful waiting, gate keeping and continuity of care.

These shortcomings of US primary care have recently been documented by Schoen and colleagues in a survey of primary care in 11 countries. We quote: ‘although the United States spends far more than the other countries do, US primary care physicians continue to lag well behind in health IT capacity, are the least likely to have arrangements for after-hours care, and report few incentives or targeted support for improving primary care’.

However, while this survey was being conducted, a revolution in thinking has been occurring in US primary care, spearheaded by a number of high-level physicians’ organizations. The American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), the American College of Physicians (ACP) and others collaboratively produced a statement about a new way of organizing primary care called the Medical Home. Entitled ‘Joint Principles of the Patient-Centered Medical Home’, the statement comprises ideas about quality, organization, information technology and continuity of care and can be summarized as follows.

At the patient/practitioner level:

- an ongoing relationship with a personal physician trained to provide first contact;
- a team of clinical professionals who take responsibility for ongoing care;
- a whole-person orientation encompassing all stages of life including acute care, chronic care, preventive care and end of life care;
- a compassionate and robust partnership among physicians, patients and patients’ families;
- active participation by patients in decision making about their care;
- feedback to ensure patients’ expectations are being met; and
- enhanced access to care.

At the practice level:

- care coordinated across locations: hospital, home, nursing home and community;
- disease registries and information technology such as electronic medical records (for care provision, performance measurement, patient education, communication and health information exchange);
- evidence-based medicine and use of clinical decision-support tools;
- practice advocacy to support optimal, patient-centered outcomes;
- patient care quality and safety as hallmarks, with patients and families participating in quality improvement activities at the practice level; and
- voluntary physician engagement in performance measurement and quality improvement.

At the system level:

- a recognition/accreditation process to demonstrate that practices provide patient-centered services consistent with the medical home model; and
- payment to physicians that recognizes the added value of the patient-centred medical home.

Who could disagree with these concepts and ideas? Like ‘motherhood and apple pie’ they are so plainly good that no one could argue against them. The concepts constitute a rallying call for change in health care with which all patients and many practitioners would heartily concur. In many European countries, some of these concepts are already well embedded, such as in the Netherlands and Italy. In the UK, General Practitioner (GP) training contains a curriculum (and examinations) with such themes as consultation, clinical governance, clinical ethics and values-based practice, evidence-based practice, information management and technology, and the promotion of health and prevention of disease that, together, would clearly equip a practitioner to work in a Medical Home.

The Medical Home model in the USA is in a nascent stage of development, largely because the predominant form of payment to primary care physicians is still fee-for-service and the independent nature of most physician practices does not lend itself to the formation of the more integrated service delivery systems and networks familiar to many European nations. Nevertheless, early findings from several Medical
Home demonstrations are encouraging and the Affordable Care Act of 2010 promotes the adoption of patient-centred care. What can the UK and other European nations learn from the US experience? Perhaps the most obvious lesson is that the Medical Home model—with its emphasis on patient-centred, comprehensive and continuous primary care—has some excellent ideas about how to promote health, prevent disease and contain costs, as part of compassionate, affordable care for people with complex or chronic conditions. In the USA, the success of this approach will depend on aligning the necessary political will, policy support, underlying incentives (financial and professional), and creative, inspired training to implement and disseminate the Medical Home model throughout the health care system. Indeed, the same challenges would be faced in all nations. Policymakers need to assess how patients’ interests may best be served in the long run.

The ethos underlying the Medical Home idea is admirable. In Europe, we should watch developments closely. Unusually there may be lessons to be learned from the USA about how to organize primary care that may benefit our own populations.

Funding
We are grateful to the Boston University-University of Warwick Strategic Funding Initiative for support of this work.

References
3 Patient Protection and Affordable Care Act, S. 6301, 111th Cong., 2nd Session, 2010.

doi:10.1093/eurpub/ckq146

A vision revisited: two years later on health reform in the USA

Joe Smyser, Thomas E. Novotny
San Diego State University, San Diego, CA, USA

Correspondence: Thomas E. Novotny, Hardy Tower 119, 5500 Campanile Drive, San Diego State University, San Diego, CA 92182-4162, USA. e-mail: tnovotny@mail.sdsu.edu

For the first time in history, we will have a major reform enacted without a bipartisan support for doing so. We’ll challenge it every place we can ...we’ll fight everywhere.

John McCain, Republican Senator from Arizona, 22 March 2010

Today we are affirming that essential truth, a truth every generation is called to discover for itself, that we are not a nation that scales back its aspirations.

Barack Obama, President of the USA, 23 March 2010

In this Journal in 2009, we described the scenarios that might be expected as President Barack Obama occupied the White House and advanced his commitment to health care reform and global health in the USA. This article provides a brief commentary on where this ambitious agenda now stands.

Things have changed
Before Mr Obama’s election, he described five priorities for his administration: economic stimulation, energy, health care, restructuring taxes and education. Since taking charge of the office on 20 January 2009, the President has seen these priorities shift in the face of a still-flailing economy, scaling down of the Iraq war and escalation of the Afghanistan war, the worst oil spill in US history and an increasingly vocal opposition. This backlash, showcased by the conservative splinter group known as the ‘Tea Party’, focuses on two key issues: the economic stimulus package—a $787 billion effort to recover jobs and shore up the economy—and health care reform, a key promise of his campaign.

Kick-starts, kickbacks and kick-offs
The late Ted Kennedy, Democrat Senator from Massachusetts, first introduced health reform legislation on 5 June 2009. When Kennedy’s illness overtook him, Democrat Chris Dodd moved the Affordable Health Choices Act through the Senate as the first tangible effort to kick-start health reform. It called for strengthening Medicare (the national insurance plan for disabled persons and seniors), covering all citizens with health insurance, cost saving through information technology, insurance exchanges to ensure competitiveness and a requirement that all Americans have health insurance. There was essentially no Republican support for this.

The Administration took core proposals to the people in August in a series of national town hall meetings. Public response was chilling, revealing the messy processes involved in ambitious social reforms such as this. Legislators were shouted down, effigies were burned and threats of violence reported. Two main points of contention were the ‘public