some common tools (sentinel-event reporting and root-cause analysis) and some less common ones (monitoring of protocol overrides and rapid-cycle experimentation). Some have units — for instance, the Mayo Clinic's See-Plan-Act-Refine-Communicate (SPARC) program — that are dedicated to developing innovations in-house, and most have academies to teach leaders and staff the principles and techniques for improving the value of care and to support the application of these principles to high-priority clinical programs and processes. Most important, these organizations deliberately nurture a culture that supports learning by encouraging dissenting views and overriding of specified clinical decision rules (habit 1).

These habits are not unique to high-value health care organizations. Many delivery organizations engage in some of them — designing clinical pathways and reporting on quality and safety, for instance. But high-value organizations are distinct in two important ways. First, they engage in all four habits systematically. For them, these activities are truly habits, baked into their structures, culture, and routines, not simply short-lived projects. Second, the habits are integrated into a comprehensive system for clinical management that is focused more on clinical processes and outcomes than on resources. A consensus is emerging about how to manage clinical care.

Each organization expresses these four habits differently. Each faces a unique regulatory and reimbursement environment and has different resources, so each uses different tools and terminologies, varying in the details of how they specify decisions or measure clinical processes. Still, the habits are the same. As we seek models for achieving high-value health care, we must look past the particularities of local structures and tactics to the habits they reflect. Although a "dominant" delivery model may not be transferrable, the habits of high-value health care may be.

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2012 — A Watershed Election for Health Care

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The 2012 election will be the most important in the history of our health care system because it will determine whether the Affordable Care Act (ACA) is implemented or repealed. The consequences for Americans and their health care will be huge.

Three possible federal electoral outcomes seem most likely. All assume that the Republicans will retain control of the House of Representatives, though perhaps with a diminished majority. Under the first scenario, the status quo continues with President Barack Obama in the White House and Democrats controlling the Senate; in the second, Obama is reelected but the Senate goes Republican; in the third, the Republicans recapture the White House and control both houses of Congress.

Electoral math makes the first of these possibilities a long shot. The Democrats have a three-vote majority in the Senate, but 23 Democratic seats will be contested in 2012, as compared with only 10 Republican seats. In a time of fierce anti-incumbency, it's much harder to defend 23 seats than 10. The Democrats also have notable vulnerabilities. For example, Senator Kent Conrad (D-ND) is retiring in a solidly Republican state. Senator Bill Nelson (D-FL) is running in a state that elected a Republican governor and senator in 2010. The most vulnerable Republican senator, Scott Brown of Massachusetts, continues to poll well and will face an inexperienced Democratic challenger.

Each scenario has different implications for the ACA and its agenda (see table). If the status quo persists, the President will continue implementing the legislation unless the Supreme Court rules the entire law unconstitutional. If the Court overturned

Probable Effects of the Three Most Likely Outcomes of the 2012 Elections.

Electoral Outcome	Effect on ACA Provisions	Effect on Health Care System
Status quo (Obama reelected, Democratic Senate)	Continued implementation of ACA coverage and delivery-reform provisions, barring Supreme Court decision to overthrow entire law	Reduced rates of uninsured persons in the United States Aggressive implementation of ACA health system reform provisions
Republican Congress (Obama reelected, Republican Senate and House)	Even if the Supreme Court upholds the law in its entirety, political stalemate leads to compromise that reduces funding for coverage expansions, slows implementation of state health insurance exchanges, and reduces funding for health system reforms	Maintenance of near pre-ACA levels of uninsured Americans; no substantial growth in levels Less aggressive implementation of ACA health system provisions
Republican government (Republican President, Republican Senate and House)	Repeal of coverage provisions of ACA, without replacement Retention of system-reform provisions that do not require federal expenditures (e.g., value-based purchasing, demonstrations of patient-centered medical homes)	Resumption of pre-ACA rates of growth in the numbers of uninsured Americans Federal health system reform activities that are similar to pre-ACA activities

just the individual mandate to obtain health insurance, the administration would push forward with many other ACA provisions, including establishment of health insurance exchanges, expansions of Medicaid, federal subsidies supporting the purchase of insurance, and employer penalties for not providing coverage. The same would apply to provisions intended to spur innovation and improvement in the efficiency and quality of health services, including the Center for Medicare and Medicaid Innovation, value-based purchasing programs, and other initiatives.

Republicans would continue trying to slow implementation by reducing funding for the program, and with current budgetary pressures, they might have some success. However, the President's reelection and Republicans' failure to capture the Senate would deprive Republicans of a mandate to turn back the ACA, and their attacks would probably diminish. Most ACA provisions would survive, insurance coverage would expand, and the federal government would retain the law's tools for pursuing delivery-system reform and curtailing costs.

Under the second, more likely scenario, the outcome looks very different. The Republicans would portray their Senate capture as a repudiation of the ACA and launch a strong, persistent attack on it. They would force the President to veto repeals of the legislation and budgets defunding its key elements. They would hold other presidential initiatives hostage to their health care reform demands. Over time, this trench warfare would take a toll on the President's political standing, the functioning of government, and the administration's ability to resist.

The resulting compromise is difficult to predict with certainty, but it would most likely change the ACA's course significantly. For example, ACA revisions might substantially reduce funding for Medicaid expansions and insurance subsidies or repeal employer penalties for not covering employees. The compromise might strip away the President's authority under the ACA to set up insurance exchanges in states that refuse to do so themselves. To date, only 15 states have enacted the necessary provisions. Especially if the Supreme Court overturns the individual mandate, such changes could pare back the extension of insurance coverage dramatically. Even if the mandate survives constitutional challenge, it may not be effective or politically sustainable if funds for insurance subsidies for low-income Americans are reduced significantly. Even Democrats will not support requiring citizens to purchase coverage they can't afford.

As for delivery-system reform, the most likely changes would cut funding to pricey initiatives: the $500 million per year for the Patient Centered Outcomes Research Institute, the $15 billion prevention fund, and the $10 billion Center for Medicare and Medicaid Innovation. These changes and persistent attacks on the law could dramatically reduce the administration's ability to undertake ambitious, politically delicate delivery-system reforms.

Under the second scenario, therefore, ACA implementation could slow considerably. A modest number of Americans will gain new coverage — but perhaps only a few million more than will lose coverage owing to continued deterioration in private insurance markets. Our health care delivery system will probably look much the same in 2016 as it does

now. From the administration's standpoint, the major bright spot would be that the ACA, or parts of it, would remain on the books, available for future revival.

Under the third scenario, Republicans will have a mandate and the ability to repeal the ACA and will probably do so quickly, using the so-called reconciliation process, if necessary, to overcome a Democratic filibuster. At most, they may retain a few of the law's politically appealing elements, such as the expansion of prevention and drug benefits under Medicare. The Republicans may also preserve some delivery-system-reform initiatives that require no or modest new federal spending: experiments with bundled payment, pay-for-performance initiatives, patient-centered medical homes, and increased Medicare and Medicaid payments for primary care physicians. However, given the antigovernment sentiments so prevalent in the Republican Party, it seems unlikely that they'll use these authorities aggressively to lead comprehensive delivery-system changes. Since this electoral outcome will probably end the Obama reform initiative, it will render moot the Supreme Court's review of the constitutionality of the ACA.

The Republicans could, of course, try to replace the ACA when they repeal it. For several reasons, however, they may not attempt this, or fail if they do try. Even as a popular new president with control of both congressional houses, Obama found it extremely difficult and politically painful to reform our health care system. That's because the 84% of Americans with health insurance remain extremely suspicious of any governmental effort to change the health care system. After a divisive 4-year struggle in which opponents have argued that the Obama program will leave most Americans worse off, a majority of voters may be comfortable returning to the pre-ACA state. But that doesn't mean they will support another reform effort that could be portrayed as threatening something that Americans hold dear.

Take, for example, the traditional Republican approach to covering uninsured Americans: an individual tax credit subsidizing purchases of private health insurance funded by ending the tax exemption for employers' contributions to employees' health insurance. Many employers and employees oppose this idea, and it would be difficult to pass without a major political fight. Historically, Republican presidents have been reluctant to take on the political costs of comprehensive health care reform, and the last thing a new Republican president will want is to fall on the political sword that impaled his predecessor.

A key lesson flows from analyzing the likely election consequences. Under the two most probable scenarios, the health care system probably wouldn't change fundamentally for at least the following 4 years. That means that the proportion of Americans without insurance will not decline significantly; under the third scenario, the proportion could even continue to increase at pre-ACA rates. Governmental leadership to control health care costs through fundamental health system reform will also flag. And by 2020, 20% of Americans may be uninsured, even as 20% of our gross domestic product is devoted to health care.

Speculative as this analysis may be, it highlights the extraordinary health care stakes riding on the 2012 election. We will live with its health care consequences for decades to come.

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Geographic Variation in Physicians' Responses to a Reimbursement Change

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Although much research has revealed U.S. geographic variation in the intensity of health care utilization and the level of Medicare spending,[1] such variation in response to Medicare policy changes has received much less attention. This limitation has become more important in the face of the myriad Medicare-reimbursement changes included in the Patient Protection and Affordable Care Act (ACA). We studied the variation in geographic response to a major reform of Medicare's