people most of the time and managing access to specialist services. To do so, they will have to get the support they need to continue to provide person-centered care and to deal with the complex and delicate balance among an individual's health, illness (the perception that something is wrong), and disease (a confirmed diagnosis). General practices will have to facilitate the increasingly important interface between people's management of their own health and the care that is delivered in partnership with, or by, health care professionals. And they will have to find ways to negotiate the complex trade-offs among the sometimes conflicting expectations and needs of individuals, populations, and taxpayers, whose continuing support for a publicly funded health system is essential for its survival.

If these principles underpin future models of general practice, then it matters little how the care is structured or who is responsible for managing it. In 10 years' time, general practice in England may look very different from how it looks today, but it would be a disaster if the assets that general practice has historically brought to the NHS are carelessly lost in the name of reform.

Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

From the Department of Primary Care and Population Health, University College London, London.

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Setting Value-Based Payment Goals — HHS Efforts to Improve U.S. Health Care

Sylvia M. Burwell

Now that the Affordable Care Act (ACA) has expanded health care coverage and made it affordable to many more Americans, we have the opportunity to shape the way care is delivered and improve the quality of care systemwide, while helping to reduce the growth of health care costs. Many efforts have already been initiated on these fronts, leveraging the ACA's new tools. The Department of Health and Human Services (HHS) now intends to focus its energies on augmenting reform in three important and interdependent ways: using incentives to motivate higher-value care, by increasingly tying payment to value through alternative payment models; changing the way care is delivered through greater teamwork and integration, more effective coordination of providers across settings, and greater attention by providers to population health; and harnessing the power of information to improve care for patients.

As we work to build a health care system that delivers better care, that is smarter about how dollars are spent, and that makes people healthier, we are identifying metrics for managing and tracking our progress. A majority of Medicare fee-for-service payments already have a link to quality or value. Our goal is to have 85% of all Medicare fee-for-service payments tied to quality or value by 2016, and 90% by 2018. Perhaps even more important, our target is to have 30% of Medicare payments tied to quality or value through alternative payment models by the end of 2016, and 50% of payments by the end of 2018. Alternative payment models include accountable care organizations (ACOs) and bundled-payment arrangements under which health care providers are accountable for the quality and cost of the care they deliver to patients. This is the first time in the history of the program that explicit goals for alternative payment models and value-based payments have been set for Medicare. Changes assessed by these metrics will mark our progress in the near term, and we are engaging state Medicaid programs and private payers in efforts to

make further progress toward value-based payment throughout the health care system. Through Healthy People 2020 and other initiatives, we will also track outcome measures that reflect changes in Americans' health and health care.

To drive progress, we are focusing on three strategies. The first is incentives: a major thrust of our efforts is to create an environment in which hospitals, physicians, and other providers are rewarded for delivering high-quality health care and have the resources and flexibility they need to do so. The ACA creates a number of new institutions and payment arrangements intended to drive the health care system in this direction. These include alternative payment models such as ACOs, advanced primary care medical-home models, new models of bundling payments for episodes of care, and demonstration projects in integrated care for beneficiaries dually eligible for Medicare and Medicaid.

Looking ahead, we plan to develop and test new payment models for specialty care, starting with oncology care, and institute payments to providers for care coordination for patients with chronic conditions. Three years ago, Medicare made almost no payments through these alternative payment models,[1] but today such payments represent approximately 20% of Medicare payments to providers, and as noted above, we aim to increase this percentage. As part of this work, we also recognize the need to continue to reach consensus on the quality measures used and address issues related to risk adjustment in these new models.

Second, improving the way care is delivered is central to our reform efforts. We have put in place policies to encourage greater integration within practice sites, greater coordination among providers, and greater attention to population health. Through the Partnership for Patients, we have engaged U.S. hospitals in learning networks to focus on high-priority risks to patient safety and have already seen significant improvement. There is now a national program to reduce hospital readmissions within 30 days after discharge, which encourages hospitals to improve transitional care and coordinate more effectively with ambulatory care providers. Readmission rates are decreasing nationwide.[2] Through the Transforming Clinical Practice Initiative, we will invest up to $800 million in providing hands-on support to 150,000 physicians and other clinicians for developing the skills and tools needed to improve care delivery and transition to alternative payment models. New Medicaid health homes, patient-centered medical homes, and efforts to reorganize care for people eligible for both Medicare and Medicaid are all designed to foster greater integration and coordination.

Third, we aim to accelerate the availability of information to guide decision making. The Obama administration has led a major initiative in health information technology (IT), focusing on the adoption of electronic health records (EHRs) and their meaningful use as a central avenue for transforming care. The proportion of U.S. physicians using EHRs increased from 18% to 78% between 2001 and 2013, and 94% of hospitals now report use of certified EHRs.[3] Ongoing efforts will advance interoperability through the alignment of health IT standards and practices with payment policy so that patients' records are available when needed at the point of care to permit informed clinical decisions to be made in a timely fashion.

HHS has made a commitment to enhancing transparency in the health care market. For example, the Medicare website enables consumers to compare data on the costs and charges for hundreds of inpatient, outpatient, and physician services. Information is available on the quality of hospitals, physicians, nursing homes, and other providers, enabling consumers to make better-informed choices when selecting providers and health plans.

The ACA established the Patient-Centered Outcomes Research Institute (PCORI), dedicated to generating information that can guide doctors, other caregivers, and patients as they address important clinical decisions; PCORI is working with the Agency for Healthcare Research and Quality to disseminate this information. In the years ahead, the research findings from PCORI, disseminated in part through EHRs, can bring critical clinical information to providers and patients when they need it most, at the point of care.

Although we have much to celebrate regarding increased access and quality and reduced cost growth, much of the hard work of improving our health care system lies ahead of us. Care delivered in hospitals was much safer in 2013 than it was in 2010: there were 1.3 million fewer adverse events between 2011 and 2013 than there would have been if the rate of such events had remained unchanged, and an estimated 50,000 deaths were averted. Still, far too many hospitalized patients — nearly 1 in 10 — have

adverse events while hospitalized, and many people do not receive care that they should receive, while others receive care that does not benefit them. Growth of health care spending is at historic lows: Medicare spending per beneficiary increased by approximately 2% per year from 2010 to 2014 — a rate far below both historical averages and the growth rate of the gross domestic product.[4] Survey data show that more than 7 in 10 people who signed up for insurance in the new health insurance marketplace last year say the quality of their coverage is excellent or good.[5] However, it will take additional effort to sustain and augment the positive changes we have seen so far.

We are dedicated to using incentives for higher-value care, fostering greater integration and coordination of care and attention to population health, and providing access to information that can enable clinicians and patients to make better-informed choices. We believe that, by working in partnership across the public and private sectors, we can accelerate these improvements and integrate them into the fabric of the U.S. health system.

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Ms. Burwell is the U.S. Secretary of Health and Human Services.

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Making Hepatitis E a Vaccine-Preventable Disease

Eyasu Teshale, M.D., and John W. Ward, M.D.

Related article, p. 914

In this issue of the *Journal*, Zhang and colleagues provide data obtained from more than 110,000 healthy participants 16 to 65 years of age confirming that hepatitis E can be prevented by vaccination (pages 914–922). Initial results from this cohort study revealed that the vaccine candidate is safe and efficacious (95% efficacy over the 12-month period after vaccination).[1] The current report further shows that Hecolin (the hepatitis E vaccine licensed in China in 2011) remains immunogenic and efficacious at least 4.5 years after completion of the three-dose schedule administered at 0, 1, and 6 months.

Since Zhang et al. conducted their study in China, they found protection mainly against hepatitis E virus (HEV) genotype 4, the viral strain that is most common in that country (see map). Additional studies are needed, however, to establish the vaccine's efficacy in areas where the other three HEV genotypes predominate. In South Asia and certain areas in Africa, HEV genotype 1 is a leading cause of acute hepatitis, infecting millions of people each year and causing an estimated 70,000 deaths annually.[2] Although hepatitis E is often a mild disease, HEV infection can cause fulminant hepatitis and death. As many as 20% of pregnant women who develop hepatitis E during the third trimester may die from the disease or its complications. Large epidemics caused by HEV genotype 1 are common, particularly among people living in crowded, unsanitary conditions, such as camps for refugees, and internally displaced people. In such settings, where HEV infection is mainly transmitted by the fecal–oral route, improvements in sanitation and provision of safe drinking water cannot typically be provided at a level that halts transmission, so epidemics can be prolonged. Hepatitis E vaccination could be a useful adjunct in these settings.

Although hepatitis E is known to be a problem in these areas, the absence of precise data regarding the burden of hepatitis E disease and related deaths is a major barrier to defining the clinical and public health applications of a hepatitis E vaccine. For example, in Bangladesh, a study in which standardized interviews