(Music)

Mark Masselli: This is Conversations on Healthcare. I am Mark Masselli.

Margaret Flinter: And I am Margaret Flinter.

Mark Masselli: Well Margaret there is a new person at the helm of the department of health and human services, Sylvia Mathews Burwell sailed with relative ease through the confirmation process receiving accolades from both sides of the isle.

Margaret Flinter: It's a daunting task that you faces, HHS has a trillion dollar budget, 80,000 employees and they are really still on those first throws of the launch of the Affordable Care Act.

Mark Masselli: Not to mention the myriad other areas she must have received Margaret. She has the authority over drug regulation disease monitoring as well as medical research, all issues related to population health.

Margaret Flinter: Most recently she was the president's director of the office of management and budget before that she was president of the Wal-Mart foundation chief operating officer of the Bill and Melinda Gates Foundation and deputy chief of staff to President Bill Clinton's. So obviously no stranger to high stress, high profile jobs.

Mark Masselli: And let's say she needs to hit the ground running and that she must act quickly to set standards in place for 2015 open enrollment which technically speaking is just around the corner.

Margaret Flinter: She really has to just imbue confidence in the department's abilities to marshal its forces around the continued roll out of the Affordable Care Act but she seems to have inspired confidence in some of the nation's top politicians and corporate entities thus far, so I think her 10 year holds promise.

Mark Masselli: (Inaudible 1:18) secretary Kathleen Sebelius did spend some time recently thanking cohorts and supporters at the recent health data (inaudible 1:25) gathering in Washington. She noted that HHS will continue to focus on reforms that optimize health outcomes and help us really reduce the cost.

Margaret Flinter: That's something our guest today has spent a tremendous amount of her scholarly energy examining mark Dr. Elizabeth Bradley is the director of the Yale Global Health Initiatives and also the co-author of the American Healthcare Paradox by spending more is getting us less.

Mark Masselli: She examines why healthcare cost are so expensive in this country and why outcome still rank poorly compared to other industrialized

countries, we will also hear from Lori Robertson managing editor of FactCheck.org. But no matter what the topic, you can hear all of our shows by googling chcradio.com

Margaret Flinter: And as always, if you have comments, please e-mail us at www.chcradio.com or find us on Facebook or Twitter, we love hearing from you.. We will get to our interview with Dr. Elizabeth Bradley in just a moment.

Mark Masselli: But first, here is our producer Marianne O'Hare with this week's Headline News.

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Marianne O'Hare: I am Marianne O'Hare with these Healthcare Headlines. The Veterans Affairs healthcare scandal has done something that few other issues have achieved in this hyper partisan congress unite members of opposing parties and supportive swift action to reduce veteran's weights for care and whole VA officials accountable from mis-representing waiting times. The house overwhelmingly approved a bill, they would love veterans facing long waits for VA care to see private doctors to spend VA bonuses and require an outside assessment that this year's American Medical Association meeting discussion with fear surrounding yet again another failure by congress to fix the sustainable growth rate formula that reimburses physicians for treating Medicare patients. There had been a bipartisan solution ready to sales through congress but it wasn't acted upon in time before the end of the session. (Inaudible 3:15) so high over this in a long line of attempts to repeal the SGR that a decision was made to have an annual review of the AMA's lobbying efforts. A number of trade groups and accountable care organizations have sent letters to HHS secretary Sylvia Mathews Burwell urging her to take swift action. On improving impediments to implementation of telemedicine protocols such as remote patient monitoring and telehealth consults currently telemedicine is governed by a patch work quilt of restrictions on use and payment models which is in many cases hindering adoption those signing the letters comes from across the spectrum (inaudible 3:50) The American Telemedicine Association, large ACO organizations like Geisinger. Secretary Burwell has the power to overwrite some of those restrictions. I am I am Marianne O'Hare with these Healthcare Headlines.

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Mark Masselli: We are speaking today with Dr. Elizabeth Bradley, director of the Yale Global Health Initiatives and faculty director of the Global Health Leadership Institute, and she is co-author of the book the "American Healthcare Paradox - Why Spending More Is Getting Us Less" which examines reasons for America's extremely high health cost and relatively poor outcomes Dr. Bradley is a professor of public health policy at Yale School Public Health. She has earned

her bachelors at Harvard or MBA at the University of Chicago and her PhD at Yale. Dr. Bradley welcome to Conversations on Healthcare.

Dr. Elizabeth Bradley: Thank you so much Mark.

Mark Masselli: Betsy it's a great book first of all. I t was wonderful to read the American Healthcare paradox, you explore how much we are spending per capita in healthcare in this country and how we rank relative to other industrialize nations in terms of outcomes and your focus at Yale is on Global Health Initiative so you are well positioned to comment on which country has the best healthcare system in the world so can you explain to our listeners that paradox and help us understand how we actually stack up relative to other countries around the world.

Dr. Elizabeth Bradley: The paradox in the American Healthcare System is as you said we spend about one and half times to two times as much per capita any other country in the world any of our health outcomes or among some of the worst actually for instance our maternal mortality rate as six times that of Sweden or life expectancy is six years less than the best countries life expectancy is and these differences these disparities go on and on across diabetes heart disease teenage pregnancy it goes on how can we spend so much and get so little we do however get some things for that of course we do have tremendous access to high technology equipment kidney transplant knee replacements etc are some of those very, very technical pieces but when you look over all to the big health outcomes we are just not doing as well as countries that actually spend less than we do.

Margaret Flinter: So to do this work Betsy you took a deep dive all around the world and examined health data from some 30 countries and it came to the at this conclusion that while we spend close to 20% our GDP and healthcare in the United States and I think that’s roughly three trillion dollars per year. We are spending far less than other countries on social services which goes long ways in those countries to improving population health, can you give us some examples of how other countries are offsetting healthcare across by investing in social programs on the front end.

Dr. Elizabeth Bradley: For every one dollar, the United States spends on healthcare we spend another 90 cents on social services. But in western Europe for every one dollar spend on healthcare another two dollars is spend on social services so although we are all spending about the same amount of the total GDP when you look at both of these together we just favor heavily the medical care and the healthcare side and we are less favorable on the social service side. The place that we were most impressed with is really spending a moderate amount of money and getting honestly the best health outcome is Scandinavia we wanted to go there to understand what could we learn we know we can’t do the identical same thing we are much bigger we are much more diverse but what is that any mechanisms they are using that we could learn something from and

one of their collaborate ways in which they deal with us is they do at a county level they do joint budgeting and planning, for all the social services and the medical care services. Somebody in the county government could say we are going to put a little more in housing then we won't have to spend quite so much money in the emergency room and it's the same system that benefit from that offset which we really don't have in the United States to try to use our scarce dollars to make the greatest health outcome we possibly could.

Mark Masselli: You know that seems to be another one of the paradox is that everybody is talking about the social determinants of health but we don't see a lot of real activity happening in the ground is you are suggesting and you have the opportunity to sit with thought leaders for your book who figured out the foreign so can you highlight some of those organizations that are really improving care on that front end the support services, and what sort of healthcare savings on the back end have been achieved if any as yet.

Margaret Flinter: It's interesting because we found the home grown innovations in the United States across diverse sectors, so one of the learning was for us is just echoing our countries way where extremely diverse and we saw many different small level innovations. But a couple of programs I would turn to one is important Oregon called C-Train and it's a collaboration between the Oregon Health and Science University and Central city concern which is community center and the community center almost act as the hinge between what is a high tech medical care system and what is really housing immigration support legal support education nutrition cooking support, they establish a joint governance structure in which the hospital and health system actually provided support to the central city concern by placing and guaranteeing thoughts with primary care coordinators basically in the central city and any patient that was at risk for really post discharge readmissions or having intense sort of social service needs and they identified early and they called they put them on the C-Train and they got the full case management and then this community center really was engaged and help them be sure that they could access services that were already paid for often the hospitals may not even realize to connect people in but if you can just get the connection the resources is there and sometimes underutilized. The other piece we saw in this is when the healthcare system got involved with some of these community state and local social services there was an automatic okay we are going to track things, now we are paying attention, there was a certain I think rigger that came to the management of both of these kinds of services to make them both better.

They did randomize trial they found their patients at lower mortality better quality of care and the hospital is actually funding expansion to offer this service to even their high income and donor population that's coming in as patients.

Margaret Flinter: So Betsy when we are talking about health and healthcare and social spending we are inevitably going to talk a little bit about politics or the

political climate and what are your thoughts about the kinds of political incentives that might be deployed to improved social program spending specifically as a hedge against higher healthcare cause and also the degree which you think the Affordable Care Act addressed any of these issues along with the issue of un-insurance.

Dr. Elizabeth Bradley: I think the first thing that is important implication of our book is the idea really in the book is can we use as we intimated the healthcare dollar which is as you said almost 20%of our GDP can we use that significant investment. And make it in the best interests of those providers to also address some of the social determines of health and get involved with the services that are already funded at state level, our incentives now are still for the most part to provide more medical care and that's an incentive from the supply side physicians in hospitals do better financially from that, but also from the demand side patients and families we see ourselves as meeting medicine and that's a whole another thing that's quite different in the United States from for instance Scandinavia so from both sides we have an incentive system that asks us and pushes to put more and more in medical care. I think the ACA does hold some potential for us it does create a platform on which providers can collaborate they can take set part of money for a group of population and they can be held accountable for some of the health indicators not just the healthcare indicators. That is possible it would be legal it's regulatory supported through the ACA however in the early roll out of the ACA most of the indicators on which these provider groups getting together are being evaluated on are still not health indicators. They are still services so we haven't yet gone to the place, where the organization is actually rewarded for what percentage of their patients are obese what percent of their patients are housed, what percentage of their high school patients are on track to finish high school this would be an extreme forwardness and I think it will be decades before we think this way thinking a little bit more holistically about all the things that can make their patients healthy not just medical care.

Mark Masselli: We are speaking today with Dr. Elizabeth Bradley with Dr. Elizabeth Bradley director of the Yale Global Health Initiatives and she is co-author of the book the American Healthcare Paradox why spending more is getting us less you know so we are spending a lot of money we are spending 20% of the GDP, and so what's the concern about the diminishing of health spending so you have got part of it is you are going to shift some of those dollars but there is a big drive in this country to reduce costs second unravel all these initiatives if we start to undermine the economic underpinnings of the country in some ways by starting to reduce cost what are your thoughts on that?

Dr. Elizabeth Bradley: One thing we might look at is may be we are spending that what's right, but we haven't really thought through how to spend it as efficiently as we can allocating it in a way that truly will get us this spending but a much healthier population that would be the goal.

Margaret Flinter: The best accountable care organizations which are generally described as organizations of group to providers that hopefully more effectively coordinate healthcare for large populations of patients in how effective have these organizations been at improving health outcomes while seeking to contain costs what are your thoughts on that?

Dr. Elizabeth Bradley: The accountable care organizations the evidence on their impact is very mixed, if you would never look at the body of evidence coming out of our last three four five years of experimentation on this and say that is going to transform healthcare. You just wouldn't, you know on the margin with the right case management model and the proper navigation model in their right communities they are finding modest savings so that's just not something that I think we can hang on our hat on and assume that's finally going to get us out of this conundrum as you said. How do we as a public how do our communities first understand health what do we demand when we have a hurt back what do we want when we hurt our shoulder in the American world a lot of what the first thing happens is try to get in line for an orthopedic who will get you and MRI who will likely land in surgery. We have story after story in the book of places where people chose a different path to try to look at a I would say more holistic more behaviorally focused way to deal with that pain they may have in their shoulder but that concept of how the community understands what healthcare can do for it that's really core to solving and addressing this problem. Okay health that's a collective good, but how to get a governance structure around that where people can really collaborate.

Mark Masselli: Talking about it -- talk a little bit about the American Solution a new focused lot on the Scandinavian countries Norway and Sweden, tell us about those and the challenge of sort of cross walking those over to our unique culture here.

Dr. Elizabeth Bradley: Yeah well I think the challenges of really cross walking some of what we have learned in Scandinavian too the United States has a lot to do with what our phase is in our government and what we would delegate to our government to do and we use the world value survey to compare the United States to Scandinavian and that basically characterizes people the rude values about what they feel about their government income and in a quality whole set of measures one of which is trust and Scandinavian is a very high on trust and Americans not so much but we have tremendous amount of innovation and localism when you get into the local, local communities amazing things are happening like C-Train but we saw things throughout the country that were at a very local level where trusted high and that I think unlike perhaps Scandinavia our pace of change is very fast our freedom to make a new ideas is very fast, I think in some ways we may come up with more innovative things than we see around the globe, that's where we are out to really be looking at and even at the employer level.

Margaret Flinter: That's when we will continue the move from the global to the local and I have read your analysis and your thoughts on the community health center move overtime legislation funding initiatives all well intended had perhaps a unanticipated consequence of shifting the focus back much more heavily to investment in the healthcare part of it and less and in addressing the social determinants. And what a loss that's when I wonder to you think that the community health center movement 20 million patients expected to grow to 40 million has the potential to be one of these local community based and very diverse communities strategies for beginning to shift some of the investment from healthcare to social services.

Dr. Elizabeth Bradley: yes I absolutely think it is central there are a couple of pieces that I think have to fall into place to get that locus to really flourish looking at the social determinants and what happened in the early days in the 60s that really shifted things was putting the community health center movement under allowing it's revenue stream to be fully dependent on Medicaid and Medicare, which could only pay for medical care things. When that happened you know it changed the incentive system it changed the psyche, not of the people but just of what really was possible with an organizational constraint. Today we may see loosening of that it's possible I don't know how far the country will go but states are starting to be quite innovative with their Medicaid programs there are lot of more wavers that can happen for do eligible or for Medicaid only recipients in which the dollar could be used to do the combination that a community health center might tell you is going to be the most effective. Not only the medical care not only the referrals of the hospital but potentially looking at housing and I call our attention to this, I attempt I will project in LA which worked with hospitals to identify the top 10% of homeless people and basically use Medicaid dollars to work on the homelessness and other social support services through community centers first before the referral the hospital and they just had tremendous savings I mean only a couple of years but they are quoting healthcare cost decreasing by 72%.

So I feel like the provider group of community health centers is exactly where it could be but we do need the payer piece of it to align with health not healthcare in order to allow the centers to really I think flourish and what their vision has already been.

Margaret Flinter: We have been speaking with Dr. Elizabeth Bradley director of the Yale Global Health Initiatives and faculty director of the Global Health Leadership Institute she is co-author of the book the American Healthcare Paradox why spending more is getting us less you can learn more about her work by going to ghli.yale.edu or you can follow her on twitter at EHBL. Betsy thank you so much for joining us in Conversations.

Dr. Elizabeth Bradley: Thank you both very much.

Mark Masselli: At Conversations on Healthcare, we want our audience to be truly in the know when it comes to the facts about Healthcare Reform and policy. Lori Robertson is an award winning journalist and managing editor of FactCheck.org, a nonpartisan nonprofit consumer advocate for voters that aim to reduce the level of deception in U.S. politics. Lori, what have you got for us this week?

Lori Robertson: Well, do the Affordable Care Act increase income tax brackets capital gains and state taxes and 2014, that's what our viral e-mail says but it's not true, the unanimous message claims that several taxes went up on January 1st, 2014 because of the Affordable Care Act but none of the taxes listed had anything to do with the healthcare lot, most of were part of the fiscal **cliff [PH]** package that congress passed on January 1st, 2013 for instance the top income tax rate did go back up to 39.6% for singles making more than $400,000 a year and couples earning more than $450,000 that increases part of the fiscal cliff in 2013. Capital gains and dividend tax rates also went up under that deal, and not as much as the viral message claims the top capital gains rate dividend rates are both now 20% for those who are earning more than $400,000 or $450,000 a year. The e-mail wrongly says that the estate tax went from 0% to 55%. The tax is still 0% for anyone who dies this year and has in a state worth less than $5.3 million. The top rate is next to the fiscal cliff deal 40% this message goes on to claim that the tax increases it list were "passed with only democratic votes" not true at all, the fiscal cliff deal passed by a vote of 89 to8 in a senate with 40 republicans in favor. In the house 85 republicans voted in favor. The ACA does include some tax increases such as a 3.8% tax on net investment income and additional Medicare tax of 0.9% for those earning more than $200,000 a year or $250,000 for couples but that increase is no where to be found in this bogus viral message and that my fact check for this week I am Lori Robertson managing editor of FactCheck.org.

Margaret Flinter: FactCheck.org is committed to factual accuracy from the country's major political players and is a project of the Annenberg Public Policy Center at the University of Pennsylvania. If you have a fact that you would like checked, email us at Chcradio.com, we will have FactCheck.org's Lori Robertson check it out for you here on Conversations on Healthcare. Each week, Conversations highlights a bright idea about how to make wellness a part of our communities into everyday lives. Primary care providers have their work for seeing patients after patients all day in brief visits it can be difficult to cover all the important basis and often signs alcohol dependence can get overlooked and many patients are put off by lengthy questionnaires that are aimed to determining whether you have a problem with drinking or using drugs. Researchers at the Boston University School of Public Health have determined that asking one simple question could actually determine the level of a patient's possible drug or alcohol dependency. For alcohol use participants were asked how many times in the past year they had consumed five or more drinks in a day for other substance

use they are asked how many times in the past year have used illegal drug or used a prescription medication for non medical reasons.

The researchers compared alcohol screening responses with alcohol dependence reference standards and drug screening questions with drug dependence standards. The single alcohol screening questions detected 88% of those with alcohol dependence the drug question detected 97% of those with drug dependence. Lead researcher Dr. Richard states say this could provide a valuable rapid assessment for primary care providers to help patients and get them to the treatment options they need a single simple question aimed at revealing drug or alcohol dependency that could primary care providers diagnosed the problem more readily getting patients sooner to the help they need now that's a bright idea.

Margaret Flinter: This is Conversations on Healthcare. I am Margaret Flinter.

Mark Masselli: And I am Mark Masselli. Peace and health.

Conversations on Healthcare, broadcast from the campus of WESU at Wesleyan University, streaming live at Wesufm.org, and brought to you by the Community Health Center.