(Music)

Mark Masselli: This is Conversations on Health Care; I am Mark Masselli.

Margaret Flinter: And I am Margaret Flinter.

Mark Masselli: Well Margaret my kids are back in school, Congress is back in session and we are back on the air at the start of what is sure to be an exciting next few months in health care. There are lots of benefits kicking in at the end of this month at states are taking steps to set up their health insurance exchanges and temporary high risk pools and of course mid term elections loom large coming up in November. You know I saw a CNN poll from late August that said 83% of Americans considered health care an extremely or very important issue in determining their vote for Congress.

Margaret Flinter: Well we will be following the ramp-up to those midterm elections very closely, obviously that's going to have a big impact. I hope everybody enjoyed their summer. We are happy to be back. We hope you stayed healthy and cool which was hard to do in large parts of the country this summer.

Mark Masselli: It was.

Margaret Flinter: And out in California they were busy getting a head-start on setting up their health insurance exchange. The legislature passed the bill which Governor Schwarzenegger is expected to sign later this month making California the first state to set up the health insurance exchange hopefully paving the way for other states that can take action early.

Mark Masselli: Looks like Governor Schwarzenegger who is finishing up his second term has a health care vision for California and he wants to do as much as possible in that regard before he leaves office next January. He included a hi-tech Telehealth system to be included in California $60 billion infrastructure development program. The California Telehealth Network is intended to connect patients mostly in underserved areas to hundreds of hospitals and clinics statewide using broadband technology.

Margaret Flinter: And Mark, you and I have talked to some of the leaders in their pilot programs, they have really done an extraordinary job and we look forward to the rest of the country getting to follow. And while California stands out, one place we haven't heard much about in the way of health care is our nation's capital, health care for the people who live in our nation's capital that is. But according to DC's Health Reform Implementation Committee they are now moving ahead as well. They have already expanded Medicaid coverage in the district, a key component of the new health care reform law that would be

acquired in four years by all states in which they go up to a 133% of the federal poverty level for coverage.

Mark Masselli: Well that makes DC and Connecticut the only two jurisdictions so far to have expanded Medicaid coverage early. And while we are talking about our home state of Connecticut, I would like to announce that here at the Community Health Center we have just launched a national campaign to address childhood obesity, it's called Recess Rocks. It's both a contest and a program. Check us out at www.recessrocks.com, I think you will be very excited about our offerings.

Margaret Flinter: That launch coincides with the first ever national childhood obesity month and there could be no better topic to focus on. It is the number one threat to the health of children, and in economic terms, it also threatens to swamp our health care system. Let's turn to our guest who joins us from our nation's capital, Dr. Fitzhugh Mullan is the Murdock Head Professor of Medicine and Health Policy at George Washington University, he is a practicing pediatrician at the Upper Cardozo Community Health Center in Washington. He has a career that's spanned 40 years. 40 years ago he wrote his book White Coat, Clenched Fist, went on to be a physician in the National Health Service Corps and later served as its director. We are delighted that he can join us today.

Mark Masselli: But no matter what the story you can hear all of our shows on our website www.chcradio.com. You can subscribe to iTunes to get our show regularly download or if you like to hang on to our every word and read a transcript of one of our shows, come visit us at www.chcradio.com and now you can find us on Facebook. You will find the button on our website or you can search Conversations on Health Care Radio Show.

Margaret Flinter: And as always, if you have feedback, email us at www.chcradio.com, we love to hear from you. Now before we speak with Dr. Mullan, let's check in with our producer Loren Bonner for the headline news

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Loren Bonner: I am Loren Bonner with this week's headline news. The administration announced the first round of applicants accepted into the early retiree reinsurance program. The program provides financial assistance to employers and unions to help them maintain coverage for early retirees. Nearly 2000 employers have been accepted into the program and will begin to receive reimbursements for employee claims this fall. According to a new survey of state data by USA Today, a record number of American citizens are enrolled in government anti-poverty programs. More than 50 million Americans are on Medicaid, that's up at least 17% since the recession began in December 2007 and that number is only expected to grow. Speaking of health care in the economy, the National Bureau of Economic Research published a new study that

found that the poor economy has caused Americans to cut back on routine medical care. Compared to countries that provide universal health coverage to its citizens, countries like Britain, Canada and France, 26.5% of Americans who responded to the survey reported reducing their use of routine medical care since the start of the global economic crisis. The percentages in countries with universal coverage were far less, only 5.3% in Canada, 7.6% in Britain and 12% in France. Today on Conversations on Health Care we are discussing the importance of the primary care workforce. Now that health care reform is passed, experts are trying to figure out how to provide care to the millions more Americans who will gain coverage. One report published in the august issue of Health Affairs hints at just one way we could possibly go about expanding the health care workforce. For a long time, international medical school graduates have been filling the gaps in the US physician workforce. International graduates for example now account for nearly 30% of all primary care doctors, a specialty as we are all aware of that has struggled to attract American medical students. The Health Affairs study evaluated the records of more than 200,000 patients who are hospitalized for either congestive heart failure or heart attack. After examining how their outcomes correlated with their doctors' education and background, researchers discovered that patients of foreign born primary care physicians faired significantly better than patients of American primary care doctors who received their medical degrees either here or abroad. Patients of foreign born international medical graduates had the lowest death rates, patients of US citizens who attended medical school in other countries had the highest death rates and US born and trained doctors fell in the middle. John Norcini is the President of the Foundation for Advancement of International Medical Education and Research. He says this study should ease some of the concerns people have had over the years about how good the regulatory process is for international medical graduates training in the US as well as the care they give their patients.

John Norcini: There is no difference between international medical graduates as a group and US medical graduates as a group. So I think the takeaway is that given the limitations of the study, the regulatory process seems to be working well.

Loren Bonner: Even if international medical students are not the answer to the primary care workforce shortage in the US, Norcini thinks it should give patients reassurance nonetheless. Let's turn now to our interview with Dr. Fitzhugh Mullan who can give us his thoughts on building a strong primary care workforce and a better health care system for all populations, something he has worked his entire career to establish.

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Mark Masselli: This is Conversations on Health Care. Today, we are speaking with Dr. Fitzhugh Mullan, a physician, educator and public health leader whose

career has spanned more than 40 years. He is currently the Murdock Head Professor of Medicine and Health Policy and a professor of pediatrics at George Washington university and a practicing physician at the Upper Cardozo Community Health Center in Washington DC. Welcome Dr. Mullan.

Dr. Fitzhugh Mullan: Glad to be here.

Mark Masselli: Your career has spanned 40 tumultuous years in health care and your book White Coat, Clenched Fist was described as a memoir but you wrote it in 1976 still early in your career about the injustices in the health care system. With many others, you have made the elimination of those injustices which lead to profound health disparities based on race _____ 9:07 insurance, a cornerstone of your work. From your perspective today, what has been accomplished and what do you see as the key battles still to be won?

Dr. Fitzhugh Mullan: Well I would start by saying I do think we made progress. Things are I think a good deal better in terms of equity than they were 40 years ago. I say that without any sense of braggadocio but to look at the evidence that suggests we are doing better. I think the huge racial gap in the country is hard at this point in time to appreciate. You have improved statistics in a variety of ways, improved health outcomes among African-Americans in particular, which despite the gap still remains, represent major steps forward and something of a closing of the gap. I think you have in terms of health career opportunities a fairly serious, fairly coast-to-coast effort to improve opportunities for disadvantaged and unrepresented minority students which was not the circumstance. I went to medical school, graduated in 1968; we had one non-white student and he came from Nigeria.

Margaret Flinter: Well much of your work in writing has certainly focused on the whole issue of training and education of health care professionals and particularly primary care providers and you have written about the impact of graduate medical education caps about the rule of non-physician providers in primary care, most of the need to reform medical education generally to prepare for the demands of the 21st century. So certainly a major focus of the Patient Protection and Affordable Care Act is the health care workforce. We would be interested in your thoughts on whether that bill went far enough to address the issues of looming primary care provider shortages and whether you think the remedies prescribed expanding the National Health Service Corps which you were once the director of, loans and scholarships, community based residencies are the right ones to address the problems or did you have recommendations that did not find their way into the legislation?

Dr. Fitzhugh Mullan: In regard to workforce, I think we got some very appreciable new tools. The increase in the size of the National Health Service Corps coupled with the increase in the size of the funds available for community health centers really will provide a much stronger and much less porous safety net I think a few

years out. The incentives on primary care I actually think that the toughest long term issue for the country is the whole issue of generalist care and developing both a workforce as well as a patient population that will appreciate the importance of generalist care which we call primary care but it's a generalist approach is a real challenge because the incentives have all been laid the other way. So on making those incentives and rebuilding ones that will make primary care as attractive a career as specialty care and make populations understand the importance of having good generalist care for prevention, for education, for dealing with 90% of what ails all of us all of the time, getting that message through is really tough one.

Mark Masselli: Dr. Mullan, I want to get back to that your fellow student from Nigeria because you have been equally concerned with the workforce issues abroad and while foreign-trained doctors make up an important part of our health care workforce, the issues of equity in other countries especially poor countries are aggravated when we deprive these countries of trained doctors. And as we try to find ways to expand and diversify our health care workforce now that millions more will have insurance when the exchanges roll out, will this only get worse and what are the alternatives that you are contemplating?

Dr. Fitzhugh Mullan: Well we have developed an enormous dependence on international or foreign-trained health workers not only in medicine but in nursing and pharmacy, home health care. We have done it because it's been cheap and easy and it's conformed to the needs to institutions who want quick labor, training institutions who have not been able to obtain or haven't sought the additional funding they need to build themselves fully out or start new institutions and finally, of course, the foreign workers are eager to get into this country. What we need to do is wean ourselves from our dependence on foreign labor for two reasons, one is it's not good for us and secondly it's not good for the countries who are paying to train folks only to have them siphoned off after the investment's been made in them to the industrial world, ourselves in particular. It's what I call reverse foreign aid. I mean we are busy giving out foreign aid on the one hand and particularly in health and medical education and then on the other hand, we are setting up a market situation that sucks that labor right into our country, not for the country either country involved. And the answer to it is being much more attentive to the educational requirements that it will take to build a workforce of the size and type that we need and that means long term educational funding and investment which we at the federal state, local and personal level have been remiss to do.

Margaret Flinter: Dr. Mullan, I think of you as one of the individuals who brought the concept of community oriented primary care into the mainstream of health care, a focus on the needs of a community on a defined population of patients and responding to the needs of that population based on data and based on the wishes of that community. And as we struggle with the obesity epidemic I am always reminded of how important that is. That approach requires both a strong

public health system as well as a strong personal health care system. So I would ask you would you modify or redefine the concept of community oriented primary care for today's health care needs?

Dr. Fitzhugh Mullan: I recently reviewed a volume that Jaime and Rosa Gofin have published on community oriented primary care and community oriented public health. They are expanding the concept. I thought it was an interesting expansion. My own belief and maybe I am old school is that the basic principles of COPC community oriented primary care are valuable, viable and way underused and the essence of it is using public health precepts in the pursuit of clinical practice. Most of these work one-on-one not only in our time we are seeing patients one-on-one but we also think one-on-one and have little reference to what the larger picture is in our community or in our region or in our state and what the larger numbers tell us about the likelihood of a given condition being prevalent in our population. COPC invites a practitioner to be cognizant of the bigger picture and spend his or her energies not just clinically but in the efforts of the practice or of the enterprise of the doctor as a whole or the clinic as a whole undertakes community interventions, specific campaigns. The ability to know the bigger picture even as you pursue direct patient care will make you and your practice more efficient. That's COPC and I think it has a great deal to offer in all aspects of our system.

Mark Masselli: Today, we are speaking with Dr. Fitzhugh Mullan, Professor of Health Policy and Pediatrics at George Washington University. Dr. Mullan, you have written numerous books and articles on medical and health policy topics. You were the original editor of a popular column Narrative Matters in Health Affairs which features first person narratives and stories that illuminate often complex health policy issues and you still serve as a contributing editor but can you tell us what that type of contribution or that type of writing as to health care or is there evidence to suggest that it makes doctors or health care providers better practitioners?

Dr. Fitzhugh Mullan: Certainly there has been a robust response to the column in terms of people writing, wanting to tell their stories, clinicians and others. Additionally, there has been number of reader surveys and others of Health Affairs and it's always rated very high and many say they read it first and the premise we started it on that it's often easier to get a policy message packaged in a story than it is in a table or a statistical approach. Both, obviously as a rule we are not against formalized evidence but the human tradition of telling stories has been around since man started and will be around I daresay as long as we are.

Margaret Flinter: I will admit to being one of those people who read Narrative Matters first. So Dr. Mullan, let me if I can return to that book that you wrote, White Coat, Clenched Fist for a moment. It's a title that captures the anger and the activism of a generation of young students of the health professions and I

read a review of that book from somebody who wrote about the vulnerability of the ill even for doctors when they are sick saying that there are rarely clenched fists in a hospital bed. I think that's a pretty good metaphor for new doctors and nurses in today's health care system where the stress and the demands are overwhelming and maybe not so conducive so activism. From your perspective, do you see that call to action and activism in the students you work with today that many of us felt early in our careers?

Dr. Fitzhugh Mullan: That's a good question Margaret, I get asked that from time to time. I think it waxes and wanes a little bit in terms of the tenure of the country as a whole. What I will say is I think that the idealism resident in health profession students always catches me by surprise. I mean you can sit back and think right now they want activism or they ought to be or whatever and then you sit with a group of students who are concerned about an issue and are willing to put in their nights and their weekends or their summers to do something about it, it is always energizing for me, and that reservoir is there. I think today, interestingly, the enormous outpouring of interest in global health and particularly in Africa is a manifestation of that. I have often wondered is it out of frustration with our own country that the sense of motion or to put it differently, the sense of frustration for those trying to change, improve the system has been so battered or beaten about that the opportunities to make a difference abroad have an appeal that they mightn't if things were moving better or quicker here. If indeed the current legislation begins to move and change the system, will the opportunities for students to become more active and not just in protesting but in terms of staffing, working with, and helping to improve the system when they return home will repatriate them, I think it will be interesting to see.

Mark Masselli: Speaking about where we go in Africa and points beyond, when you look around the country and the world, what do you see in terms of innovations and who should our listeners at Conversations be keeping an eye on?

Dr. Fitzhugh Mullan: We are in an effort of burgeoning once again or developing new health institutions, health professions institutions. Particularly in medicine after 25 years of no new medical schools, there are now some 12 allopathic schools and roughly an equal number of osteopathic schools that have either come online recently or coming online very shortly. A number of these have fairly innovative new models in terms of their educational mission. I like to think of them in terms of Flexner and post-Flexner with this being the 100th anniversary of the Flexner Report. Flexner for all the success he had and brought to us in terms of quality regularizing standardizing medical education which was all over the lot before him and also highly specified limited and arguably rigidified it so that many students who were not first rate test takers and scientists were denied admission. I think we are seeing innovations in looking beyond that and places like the _____ 22:10 still school in Flagstaff, Arizona, an osteopathic school which is

using community health centers as the basic teaching platform for the latter three years of medical school.

Margaret Flinter: Today, we have been speaking with Dr. Fitzhugh Mullan, the Murdock Head Professor of Medicine and Health Policy and Professor of Pediatrics at George Washington University and a practicing physician at the Upper Cardozo Community Health Center in Washington DC. Fitzhugh, thank you so much for joining us today.

Dr.Fitzhugh Mullan: My pleasure.

(Music)

Mark Masselli: Each week Conversations highlights a bright idea about how to make wellness a part of our communities and everyday lives. This week's bright idea comes to us from Massachusetts where three health centers are experimenting with a new tactic for combating obesity prescribing more fruits and vegetables. The project Prescription Produce centers on doctors prescribing their patients coupons from local farmers markets. The coupons amount to a dollar a day for each member of the patient's families although Farmers Market Voucher Programs have been used in Massachusetts for decades this project is unique because it specifically targets obesity and doctors actually write prescriptions that are filled at Farmers Markets rather than simply issuing coupons. The target patients are obese or at risk of becoming obese and most live in neighborhoods where healthy produce is expensive and hard to come by. The project's goal is not only to increase patients' access to fruits and veges but in the short run, to increase daily consumption of these essential foods by one serving a day. On a larger timescale, participants hope patients will establish consistently healthier eating habits. The pilot project will include 50 families at the three Massachusetts health centers. The project's designers see this program as vital because long lasting health improvements will only endure if an increase in fruits and vegetables is coupled with an equal or decrease in sugary high fat processed foods. So patients will learn how to make better diet choices while receiving the resources to make those choices a reality. To gage the pilot's success, doctors will monitor their patients' eating patterns and attitudes, body mass index and weight change. The Ceiling and Visibility Unlimited Foundation which sponsors the program is also working on expanding it through a year round partnership with local grocery stores so that the closing of our Farmers Market in the winter will not set patients back. By increasing immediate access to essential fruits and vegetables, the Massachusetts Prescription Produce Project is tackling obesity head on and helping people establish life long healthy eating habits. Now that's a bright idea.

Margaret Flinter: This is Conversations on Health Care; I am Margaret Flinter.

Mark Masselli: And I am Mark Masselli, peace and health.

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