Dr. Charles Alessi

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Margaret Flinter: Welcome to Conversations on Health Care with Mark Masselli and Margaret Flinter, a show where we speak to the top thought leaders in health innovation, health policy, care delivery, and the great minds who are shaping the health care of the future. This week, Mark and Margaret speak with Dr. Charles Alessi, senior advisor for dementia prevention at Public Health England. Dr. Alessi talks about the benefits of the UK's health system and its lack of barriers to primary care as well as the nation's commitment to addressing loneliness as a key health concern, especially for the elderly.

Lori Robertson also checks in, the managing editor of FactCheck.org, looks at misstatements spoken about health policy in the public domain, separating the fake from the facts.

We end with a bright idea that's improving health and well-being in everyday lives. If you have comments, please email us at chcradio@chc1.com or find us on Facebook, or Twitter, iTunes, or wherever you listen to podcasts. You can also hear us by asking Alexa to play the program, Conversations on Health Care.

Now, stay tuned for our interview with Dr. Charles Alessi of Public Health England on Conversations on Health Care.

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Mark Masselli: We're speaking today with Dr. Charles Alessi, senior advisor for dementia prevention at the Public Health England, the United Kingdom's Public Health Agency, dedicated to protecting and improving population health and reducing public health inequities. Dr. Alessi is a long time primary care physician with a focusing on strategies that can prevent the onset of dementia. He has served as chairman of the National Association for Primary Care in the UK at the National Health Service, the NHS. Dr. Alessi is currently a professor in the MBA in health innovation program as well as professor of clinical neuroscience at Western Ontario University in Canada.

Dr. Alessi, welcome to Conversations on Health Care.

Dr. Charles Alessi: Thank you.

Mark Masselli: Yeah. As a primary care clinician with a long history working with the NHS, England's National System, responsible for delivering health care to all residents in the country, there are some similarities, but also vast differences between our respective health systems. I'm wondering if you could share with our listeners how the National Health Service functions and how Public Health England is able to

better partner with NHS to advance health initiatives that impact population health.

Dr. Charles Alessi: The NHS is an organization, which was set up just after the Second World War. Basically, it delivers health care free at the point of delivery to the population of England, and it delivers that irrespective of the ability of people to pay for the service. It delivers health care on the basis of clinical need rather than ability to pay. It's paid for out of the taxes of each individual associated with the way we pay tax in the United Kingdom.

The NHS is open to everybody. Classically, what tends to happen is the moment somebody is born, they tend to register or rather their parents tend to register them with a general practitioner who holds that clinical record. The clinical record is held by that general practitioner for the whole of that individual. Only one record is kept for an individual and there is only one practitioner which is responsible for that care. This has significant advantages because what tends to develop is a very long standing relationship, a lifelong relationship between an individual and their clinician. Primary care is the first port of call. Actually 90% of all clinical episodes take place in primary care. Only about 10% take place in hospitals.

Margaret Flinter: Many organizations that we partner with are on the front lines of serving a population, which many would call underserved in the United States. Many of them have really traditionally been locked out of access to most primary care services outside of community health centers until the passage of the Affordable Care Act. We have always been so intrigued to talk with our British counterparts about the sense of everyone having access to comprehensive primary care and not just primary care, but all services with little or no out-of-pocket costs. What happens to population health in the presence of this national access to primary care?

Dr. Charles Alessi: Well, I wish I could say that the solution is purely around access to primary care. We still have levels of inequality within our system, which are associated with lower socioeconomic groups, which despite the fact that they have access to primary care facilities often choose not to access them, despite the fact that they are not charged any money to access them at all. I think we can learn from other countries in terms of the way we manage disease and the way people think of disease themselves.

If you look to some jurisdictions, places like Singapore where people have a real understanding associated with sense of community and sense of belonging to a community. I think part of that is also our responsibility as clinicians because we tend to practice some, what I

call, [inaudible 00:05:18] body part rather than really deal with people quite as comprehensively as we could do.

Primary care services are incredibly important, of course, because it's the only way you can manage a population. You can't really eliminate clinical risk from every individual by each individual going to hospital when they need to. It just doesn't work like that. We have very good examples of how it doesn't work, particularly in terms of the amount of money it costs to exclude illness without getting clinical benefits associated with it. What is important is the services that are available to people in a primary care environment needs to be sensitive to that culture, needs to be sensitive to their needs, and preferably needs to be delivered by people who are amongst them. In other words, having neighborhood arrangements is probably the best way to deliver services. That's certainly been the experience of a lot of middle income countries I have developed primary care services, and some of which have really quite excellent health services in general.

Mark Masselli: Let's take a closer look at your specific areas of expertise in your ongoing work at Public Health England. That's the prevention of dementia. Our health system as well as yours is bracing for what's being referred to as a Silver Tsunami with millions of Americans as well as Britain's already diagnosed with some form of dementia that I'm wondering if you could again share with our listeners some of the strategies for dementia preventions being deployed under your direction.

Dr. Charles Alessi: Thank you. Well, the key message is of what's good for your heart is good for your brain. Dementia is not an inevitable and normal part of aging, even though aging is one of the risk factors associated with dementia. There are ways to reduce the risk of developing dementia. Many of these are common to reducing cardiovascular risk. There are actions that we all can take to reduce the risk of developing dementia. These are taking regular exercise. This is particularly important. Not smoking. This is extremely important. A healthy balanced diet, maintaining a healthy weight, not drinking too much, and keeping socially and mentally active.

Social engagement is really important and education is also really important. Really managing to try to remain engaged and involved with your community is of extreme importance as well as this also includes ensuring you manage risk factors like blood pressure, ensuring you manage your diabetes particularly well if you are diabetic, and ensuring that if you have something like atrial fibrillation, which is a condition associated with an irregular heartbeat, that is properly treated.

The science isn't quite as good as it could be yet. We're not sure exactly why there's an association between pollution, for example, and particulates. There's another association between hearing loss. Perhaps it's associated with social isolation and certainly an association with depression.

Margaret Flinter: Well, Dr. Alessi, you've said that the problems of aging are not going to be solved just by the medical community, but by a greater understanding of activity within the community. You've noted that sometimes interventions as simple as a national walking program, which I understand has proven successful in the UK to help treat depression, is to get people more active. These things both have a significant impact and I think equally importantly, they don't always require the intervention of a health professional. We know in health care that behavior change can be a heavy lift and, gosh, we certainly see this around diet and eating, and getting people to think about a different approach.

Maybe you could talk with us a bit about some of the community-based initiatives that the National Health Service may be engaged in, but that are really being carried out at the community level that are filling an important role in chronic disease prevention in the UK.

Dr. Charles Alessi: Yes, thank you. I think this is really important. Giving people meaning and purpose in life is of fundamental importance. What would I do if I woke up every morning and I didn't know why I was here, what I was going to do today? Being in employment, in other words, being connected with the people around you, being conscious of your environment, knowing who your neighbors are, helping your neighbors, trying to learn something every day, this is all part of giving people meaning and purpose. I think a lot of what we're trying to do is to ensure we give people meaning and purpose.

The walking program was a mechanism because, one, it got people to talk to each other, which was particularly helpful because it started to engage people with their neighbors. While they were doing that, they were also improving their step counts, which we know is of value anyway. You're killing two birds with one stone. In essence, the most important thing is to remain connected.

Now, if you do that through work, or you do that through hobbies, or you do that through helping people, I don't think it really matters, as long as you feel you have meaning and purpose in your life. If you don't, then life doesn't stop to be worth living. We see the effect of that really quite readily in how long it takes for people to die. People tend to die relatively quickly when they lose meaning and purpose in life.

Mark Masselli: We're speaking today with Dr. Charles Alessi, senior advisor for dementia prevention at Public Health England, the UK's Public Health Agency, dedicated to protecting and improving population health and reducing public health inequities. Dr Alessi is a long time primary care physician with a focusing on strategies that can prevent the onset of dementia.

Dr. Alessi, you always hear the new axiom in the public health space, such as sitting is the new smoking, which has led to a lot of innovative approaches to address our sedentary lifestyle. We're really taken by the recent revelations that there's also an epidemic of loneliness, especially among seniors, and that the effects from such isolation are just as damaging to health and longevity as sitting or smoking. I'm thinking about the work of Dr. Robert Putnam here in the United States, who wrote Bowling Alone, the work of Nick Christakis at MIT, looking at the issues around social isolation. These are very important issues within our country as well. Your country has adopted a novel approach.

I wonder if you could talk about your new minister of loneliness in the UK and how will that person be addressing these newly recognized public health challenges of chronic loneliness.

Dr. Charles Alessi: We are very aware of the dangers of loneliness, the dangers the social isolation, very well described in the literature. The moment somebody becomes socially isolated on retirement, the health effect of that are equivalent to them taking up smoking on retirement. It really does have a significant effect upon one's life. It does have a physical effect at all. It's really quite important to think in terms of ways in which one manages the situation. Of course, this is not something which is terribly common when we lived in small villages and knew each other. It's becoming much more common as the old family values which existed in the middle of the 20th century become less prevalent in the 21st, and also with city dwelling where many of us don't even know who our neighbors are.

A lot of what the work of government and local government is around loneliness is ensuring that we'd develop things like befriending services. We work very closely with our voluntary agencies, the equivalent of AARP, and then various other charities to ensure that we develop services that befriend people, that try to introduce adult [PH 00:13:12] learning all sorts of mechanisms. The walking initiative was just one of them.

In essence, they all are pointing in exactly the same place, ensuring that people feel that somebody who cares about them, and ensuring that if possible, people care about somebody else. We know those

two things really make a difference to outcomes. They also make a difference if you have a long-term condition, which in some people leads you to remain lying in bed all day. If you have a particular interest, you may actually be able to live with that condition for longer because your life is more important. You're busy. I think this is the sense of trying to ensure people retain meaning. That's why loneliness is something and social isolation is something we're attacking with quite a significant amount of resource in England.

Margaret Flinter: Dr. Alessi, you obviously bring a depth and richness of the years of being a physician, a primary care provider, and a leader in the United Kingdom's primary care system. You're also an educator and a professor charged with teaching a new generation of health practitioners, of training this next generation. You've noted that health systems are at a dramatic turning point. Therefore, the way we teach and the way we train needs to be at a turning point where we embed all of our new health care professionals in understanding these upstream causes of poor population health.

How has this changed the way that you and your colleagues, and your education and training systems are training this next generation of clinicians? What do you see as some of the seminal changes there?

Dr. Charles Alessi: We have a lot of work to do where I'm training the physicians because the world is changing more rapidly than we can change the curricular of medical schools. People like me were trained in a period when we accumulate a whole series of levels of information and knowledge to be able to [inaudible 00:15:10] those two people. Basically, we told people what to do. We were not particularly good at listening to people perhaps as well as we could do.

What's happened now with the digital revolution is that information is available to everybody. With the digital revolution, the smartphone, the availability of information immediately, it is really important that clinicians understand that their role is changing to one where they have to accompany people and one where they don't need to tell people what to do, but they need to guide people around what they advise people to do.

I think that's a fundamental difference to the way I was trained as a physician in the 1970s. Now, I think it's more about accompanying somebody on their life journey around their non-communicable diseases, and being somebody who they can turn to and somebody who can help them make decisions, but basically, the decisions are theirs. What's also changed is the personalization of health care. People are behaving far more like consumers. I think that's not necessarily a bad thing. I think that's okay because I think we need to

understand that the system is changing and health care needs to change like everything else has changed in the 21st century.

Mark Masselli: Dr. Alessi, let me pull the thread on that transformation that you've been talking about in the health system. You've talked very passionately about, make geography irrelevant. We can start delivering these cares by Skype. We have to really reform our system and leverage these technological advances. Maybe share with us, where do you see the greatest promise for disruption and improvement with these technological changes advancing?

Dr. Charles Alessi: I think digital health is going to revolutionize medicine because the fact that information is going to be available to everybody readily is going to potentially reduce the inequalities we've been talking about and people would be able to do much more for themselves. Self care will become much common. Together with initiatives which will arise out of artificial intelligence and other technological advances, physicians that are actually not physicians, but chatbots, physicians that are really decision aids will be able to actually help us manage our health care and make decisions.

Of course, there always will be the need for a physician. I think the big challenge really is where the digital world hits the old fashioned, but still very relevant, personal wealth. I think managing that interface is going to be the biggest challenge. I think there are two options that are open to us. Either all the people in the world will change or it's up to the medical system to change. I would suggest it's up to the medical system to change because it's not very likely the whole world will change.

Really the big change is around the metrics that drive our systems. At the moment, a lot of the health systems we have are driven around activity. I think they need to move and turn to being driven by wellness. We pay our physicians when we're sick. I reckon we should pay them when we are well and not when we are sick. That change of mindset is really what's going to drive the new world and the new way of thinking.

Margaret Flinter: We've been speaking today with Dr. Charles Alessi, the senior advisor for dementia prevention at Public Health England. You can learn more about their work by going to gov.uk/government/organization/public-health-england, or follow them on twitter at PHE_uk #Dr. Charles Alessi.

Dr. Alessi, we want to thank you so much for the important work that you're doing for your perspectives on the future and for joining us on Conversations on Health Care today.

Dr. Charles Alessi: Thank you.

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Mark Masselli: At Conversations on Health Care, we want our audience to be truly in the know when it comes to the facts about health care reform and policy. Lori Robertson is an award-winning journalist and managing editor of FactCheck.org, a non-partisan, 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: President Donald Trump has repeatedly made the claim that he came up with "the greatest idea for Veterans Choice", a program that was launched in 2014 during the Obama Administration. During his midterm campaign rallies, the President made the claim several times, saying that we just passed Veterans Choice to allow veterans to see a private doctor outside the VA System if they faced a long wait for care. He told the crowd in Kentucky that it was "the greatest idea I think I've ever had".

In fact, the Veterans Choice Program was created by the bipartisan Veterans' Access, Choice, and Accountability Act signed by President Barrack Obama on August 7th, 2014. The legislation, which garnered 891 to 3 vote in the Senate and a 420 to 5 vote in the house, followed a scandal over wait times at Veterans' Affairs Facilities. Program allows veterans facing waits for appointments of 30 days or more, or veterans who live more than 40 miles from the closest VA facility to get care from eligible non-VA health care providers.

Since Trump took office, he has continued the program, signing legislation to provide funding for it and to eliminate the expiration date. In June, Trump signed the bipartisan VA Mission Act to fund the Veterans Choice Program for one more year and then consolidate it into a new Veterans Community Care Program, under which a veteran could go to a private medical provider, including travel distance and appointment time.

The Government Accountability Office said in a June report that it wasn't clear whether the choice program had improved the timeliness of care because of incomplete data. Trump has continued the Veterans Choice Program and the new law could expand eligibility or change such services, but the choice program has been in existence since 2014.

That's my fact check for this week. I'm 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'd like checked, email us at chcradio.com. We'll have FactCheck.org's Lori Robertson check it out for you here on Conversations on Health Care.

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Margaret Flinter: Each week, Conversations highlights a bright idea about how to make wellness a part of our communities and everyday lives. The prevalence of sexually transmitted diseases has been on the rise in recent years. CDC has noted 2.3 million new cases of sexually transmitted diseases in the United States last year alone. That significant public health concern caught the attention of a young tech entrepreneur, Lora Ivanova, who thought that her peers needed both better information and easier testing.

Lora Ivanova: One of every two American today is living with an STI. The vast majority of them don't know it. HPV infections that cause cancer are extremely prevalent. Then pretty much virtually every other STI has been showing rates of increase.

Margaret Flinter: She created myLAB Box, which overnights the testing kit to your address, allowing for swift, private STD testing, done in the privacy of your own home.

Lora Ivanova: Delivering those services and tests to the consumer in a way that they would actually consume them, something that eCommerce has been really excellent at. What if we found a way to deliver these vital services and testing solutions to the consumer in a way that is just as easy, convenient, and even in some cases enjoyable as they're used to and accustomed to now, with everything else in their lives?

Margaret Flinter: If someone has a positive result, they're offered a complimentary consult on the phone with a registered clinician, who can call on a prescription immediately or refer the patient for further treatment options.

Laura Ivanova: You order it online. It arrives in your house. Then all you need to do is collect a small bio sample and mail it back to the lab. You will either collect a small urine sample, you will potentially have to prick your finger for some of the infections, or you will use a swab. In a matter of about 48 hours, you'll receive a notification that your results are ready. The beauty of it is if you ever have a positive infection, you're actually eligible for a complimentary telephone consult with a health care professional in your state who can prescribe treatment. It's a

new day and age we live in, but in this day and age, we really need to adapt the way that we take care of our health as well as we are adapting the way we date.

Margaret Flinter: myLAB Box, a safe, accurate, easy way to test for more than a dozen common sexually transmitted diseases, allowing consumers to bypass the barriers that often get in the way of rapid, reliable STD testing, keeping both them and their future partners safe and in better health. Now, that's a bright idea.

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Mark Masselli: You've been listening to Conversations on Health Care. I am Mark Masselli.

Margaret Flinter: I am Margaret Flinter.

Mark Masselli: Peace and health.

Margaret Flinter: Conversations on Health Care is recorded at WESU at Wesleyan University, streaming live at chcradio.com, iTunes, or wherever you listen to podcasts. If you have comments, please email us at chcradio@chc1.com or find us on Facebook or Twitter. We love hearing from you. This show is brought to you by the Community Health Center.

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