(Music)

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

Margaret Flinter: I am Margaret Flinter.

Mark Masselli: Margaret, we have been following the court's ruling on health care law and the budget resolution in Congress; both are far from settled. We waited patiently last week to hear from Florida Judge Roger Vinson about whether or not the health care law will move forward. Based on his decision last month that ruled the law unconstitutional, last week he issued a stay which said implementation of the health care law can move forward. But with that, came an order for the government to move more quickly for the definitive decision by the Supreme Court on the law's constitutionality.

Margaret Flinter: Well, based on all of this I think that although it's Mardi Gras week there is not a lot of partying and going on in Washington. That stay was based on a condition that the Department of Justice file an appeal of his decision to the Eleventh Circuit Court of Appeals in Atlanta within seven business days of the March 3rd decision. It does look like they are going to comply with that order though.

Mark Masselli: You know I read Judge Vinson's ruling and he was ripped at the Justice Department, they really ignored his order to stop the law being implemented and he had advocates in Florida Governor Rick Scott and Alaska's Sean Parnell who were saying the ruling meant they didn't have to implement the law.

Margaret Flinter: And meanwhile, back at the ranch in Washington, Congress is negotiating the next continuing resolution and Mark, we really couldn't blame our readers if they felt like they stumbled into Groundhog Day it seems like we have been talking about this for weeks. The current continuing resolution that was signed last week will fund the government until March 18th. But Majority Leader Harry Reid has brought forth a resolution in the senate that calls for no restraints at all on the Department of Health and Human Services to fund implementation of the health law and of course, that's completely different from the CR that passed in the House. So we will have to see can they establish any common ground or we will be right back at the same place we were at last week.

Mark Masselli: We will read that chapter one more time and we will get it right this time. And we will continue to follow what's happening in both Congress and the courts and we will keep our pulse on innovations and lessons in delivering better health care from around the country and the world.

Margaret Flinter: And on that note, today, we are going to hear about some very interesting e-health projects going on in developing countries to strengthen their health systems and ultimately improve health outcomes for their population. Our guest today is Chaitali Sinha, she is Program Officer in Health, Equity Research at the International Development Research Centre, and we are so happy she can join us today.

Mark Masselli: The spread of mobile health or m-health in the realm of e-health is especially relevant to developing countries in our discussion today. It's advancing much more quickly in these parts of the world than it is in the United States and we look forward to hearing about how Chaitali's research could be applied to health care here as well.

Margaret Flinter: And no matter what the story, you can hear all of our shows on our website www.chcradio.com. Subscribe to iTunes, get the show regularly downloaded, 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 don't forget, you can become a fan of Conversations on Health Care on Facebook and follow us on Twitter.

Mark Masselli: And as always, if you have feedback, email us at www.chcradio.com, we would love to hear from you. Before we hear from Chaitali Sinha, let's check in with our producer Loren Bonner with Headline News.

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Loren Bonner: I am Loren Bonner with this week's Headline News. The Justice Department has appealed Florida Judge Roger Vinson's decision that struck down the entire health care law. It filed the notice on Tuesday in the Eleventh Circuit Court of Appeals in Atlanta asking for an expedited review of the decision. The US Department of Health has granted Maine a medical loss ratio waiver, the first state to receive such a waiver. HHS said it would delay for three years a requirement that ensures spend 80 to 85 cents of every premium dollar on medical care and quality improvement. This came after one of three insurers offering individual plans in Maine threatened to withdraw from the state. Similar requests are pending for Nevada, Kentucky and New Hampshire. Republicans have begun crafting their budget proposal for next year. House Budget Committee Chairman Paul Ryan vowed to tackle entitlement spending specifically Medicare Reform. Details are scarce but during an event sponsored by National Journal the GOP chairman reintroduced the idea of proposing a Medicare voucher system for those 55 and younger. The debate over entitlement spending has always been politically sensitive and difficult to resolve. It's extremely unlikely that a democratic-controlled senate or President Obama would approve such an aggressive change to Medicare. Both Houses of Congress have now voted to repeal the 1099 Tax Provision in the health care law

which was originally put into the Affordable Care Act to help pay for the expansion of coverage. Democrat and Republican lawmakers have agreed that the provision would have placed a significant burden on small businesses since it would require all businesses to file 1099 Tax Forms reporting any purchases they make of goods or services above $600. But there is a problem, how to recover the money lost estimated to be about $21 billion now that there is no revenue from the reporting requirement. President Obama supports the repeal but objects to the financing used in the House and Senate bills, he has not yet proposed an alternative. A new report from the market research from Frost & Sullivan finds that the global market for remote patient monitoring is growing. Demand for the technology which includes Bluetooth, Near Field Communication, Secure Data Management and Wireless Sensor Platforms is on the rise especially from groups who manage chronic diseases such as diabetes and congestive heart failure. And the demand for wireless monitoring in the last few years isn't just coming from the United States, Europe and Japan it's also coming from emerging markets like India and China. The report also says that a number of major companies such as Google, IBM, Microsoft and Wal-Mart are assisting in the development of these remote monitoring products.

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Mark Masselli: This is Conversations on Health Care. Today, we are speaking with Chaitali Sinha, Program Officer on Research on Health Equity with the International Development Research Centre, IDRC in Ottawa, Ontario. Welcome.

Chaitali Sinha: Thank you very much.

Mark Masselli: The International Development Research Centre has been working to strengthen health systems around the world for over 40 years most recently through eHealth. Can you tell us when you started exploring eHealth and eHealth initiatives as IDRC supported to improve global health and finally, how do you know where to focus your attention globally?

Chaitali Sinha: Well maybe I will take a step back and just explain a little bit about how IDRC provides support. We are a donor agency and we do focus on research like you mentioned. And the important thing to note here is that the funding that we give goes directly to the researchers and the organizations that live in the low and middle income countries where these issues are being experienced. So in terms of how long we have been supporting work on eHealth, it's been nearly a decade and it's been interesting because the way in which we support the work has been responding to the evolution that has happened in terms of health care, in terms of the health issues that are being experienced, in terms of the evolution of the technologies, in terms of the evolution of the awareness of what eHealth is. And the main thing for us is to make sure that research that is being funded is being used and that means that these individuals

should be linked up with the people and the organizations that can make change happen. So, that's one factor and of course there are other issues in terms of having enabling environments, policy issues have to be taken into account, and of course if there is an epidemic or an outbreak, there are different methods and different mechanisms that we might use to support this youth-focused research support.

Margaret Flinter: Chaitali, one of your projects at IDRC is called the PAN Asian Collaboration for Evidence-based eHealth Adoption and Application. That's a long title, it's a mouthful, but for what sounds like a very fascinating project maybe you could describe for us a little bit of what that project is specifically about, what you are learning from it and also what's the applicability to health care in the United States, in Canada where certainly we have many communities that are low income or stressed and need additional help, any lessons that we can share from that?

Chaitali Sinha: Well PANACeA which is what that big long thing ends up being as an acronym, what it is, it's a multi-country research network that we are supporting in South Asia and Southeast Asia. It's currently in its fourth year of operation and the reason why it was developed was because we had a sense that there was a need to strengthen the evidence-based of using eHealth or mHealth which is the use of mobiles within eHealth field is that there was a lot happening, there were a lot of pilots and there still are, and they are actually great but if you don't really understand what is happening in terms of the health outcomes, often times we look at things like how much does this solution cost and that's a very important thing to ask. But what often isn't asked is when you look down the chain of outcomes and influence what is the actual influence on individual and public health outcomes. And the way that it's being done is that each project is multi-country so again, we found that there was a lot of evidence that looked at what was happening in a specific part of a specific country in a specific province or state but there wasn't a lot of generalized ability in terms of the experiences that were happening on the ground and how those can be leveraged and used in other context. So that goes to your final point which is asking me about how can some of the lessons that have come out from this network perhaps be applied to Canada and the US. And I guess a broad response to that would be the emphasis on looking at locally responsive research that puts the health outcomes first and technology as a tool to understand and to hopefully improve the health outcomes, trying to be honest about sometimes when you put in something eHealth it can often lead to health outcomes that don't become better, it can strain a system, it can lead to resources being put to one issue that perhaps might compromise the health of others overall.

Mark Masselli: Well we like to talk about improving health outcomes for underserved in United States and developing world through mobile health but I think you make the good point that we don't necessarily have all of the outcome data that we need. Just a general question, how prominent is the mobile health

spread around the world and if one can generalize and where do you see it having its most positive effect on health services in the delivery of health information?

Chaitali Sinha: Still worth noting that the increase of use and coverage is much faster in lower income parts of the world and some can say that's because they didn't have much to start with so the amounts that it's improved is a lot more. Regardless, at the end of the day, there are many more people who have access to use cell phones and people who are not necessarily able to read and write and if they are, they can't necessarily read or write in English or French or any other kind of major language that's used in the world. So the spread of mobile is the foundation for a lot of the impetus behind mHealth but at the end of the day it is the health and that's why the work that the mHealth Alliance is doing along with many others is very interesting because it is looking at how it can leverage and how countries can leverage that network that is in place to then mobilize people networks and health networks and information networks. So it's a lot more about expanding the reach. The thing that I find very important to note with mHealth is that interactive capacity that's built in, whether it's interactive voice response where you can call in and you can speak with someone or you can share your information through your voice and many of these parts of the world are very orally based. So you are able to leverage that reality and you are able to do some kind of innovative thinking in terms of looking at okay well voice is very prominent, video is very, very compelling but what is it that we need to do to make these kinds of media more relevant, more accessible because I mean these things involve bandwidth, they involve networks and things like that but there again I come back to those networks are spreading. So it's all about this cyclical idea of not getting too wrapped up in the actual technology but making sure that you are being one step ahead and trying to innovate in ways that are most helpful to those that you are actually trying to help.

Margaret Flinter: Chaitali, you spoke about the importance of oral tradition around the world and we think of that in terms of storytelling sometimes. And given that it seems to me United States anyway has been a pretty different place really not there with mobile health the way much of the third world we hear is moving. I wonder if there is a story you could share with our listeners something perhaps that people have brought back from the field and told you about or that you have experienced directly that gives people a sense of really how does this impact an individual or a community, anything that comes to mind?

Chaitali Sinha: I was actually speaking with somebody and we were in Rwanda and it was talking about how we can use technologies to change behaviors to be more healthy. But there were certain locally entrenched beliefs about what would happen if you took a certain medication for a certain illness. And instead of trying to fight that with evidence and facts that are very much disembodied from stories or kind of dissociated from them, what we decided to do to explore it was how can you work within those myths that are there because you have to appreciate

their power, how can you work within them to gradually shift behaviors and to do it in a way that you are not challenging something that's been believed and that's been shared and that's been passed down for decades or even longer.

Mark Masselli: Today we are speaking with Chaitali Sinha, Program Officer with the International Development Research Centre. There is a bigger picture component to eHealth for developing countries and it can be also about moving information on to national databases so the interventions can be targeted more effectively. How have the projects at IDRC been able to provide countries with more reliable data and has the data resulted in improvements in health outcomes or increased efficiencies and are there some examples out there?

Chaitali Sinha: This is an issue that we are extremely interested in because there are more and more silos being made within health systems. So the work that IDRC has done is we have been supporting work on specific parts of the system be it in supply chain management so making sure that medication that needs to be kept cold for instance is not spoiled by the time it gets to a certain health center and then that there is enough stock there to make sure they can treat whatever is being faced in that specific area, dealing with pharmacies, etc. or whether it's medical record systems that are being automated so that you can share information and you can give care on a longer term basis. But the interesting movement now is towards something called health enterprise architecture and it sounds a little bit complicated but what it really is, it's kind of a plan for at a national level how can or how should the different parts of a health systems be it at different levels and be it in different specific health functions, how can they "interoperate" with each other. And these are technical terms so all it really means is that say if I live in village A and then every summer I go to village B because I have to work there, how can I make sure that my health record is something that I can access when I move seasonally from village A to B? And this is something that we face all the time in North America. It's not easy to get your health information when you move from one center to another.

Mark Masselli: And actually a big initiative out of the Affordable Care Act where health information exchanges are being setup all over America and yet people are struggling with just how do they handshake from one state or another or from one city to another city. So it's a problem that everyone across the globe is facing at the same time.

Chaitali Sinha: Absolutely. And it makes you realize that this issue is far more about people than it is about technologies.

Margaret Flinter: Chaitali, I would like to touch a little bit on the issue of the health care workforce in developing countries. We talk a lot in the United States about a looming shortage to primary care providers and nursing shortages but really these pale in comparison to what the third world countries are experiencing. Are there any models that have been effective for training local

health care workers in developing countries using eHealth and are you funding any research projects and have any data to talk about from those projects with regard to workforce development?

Chaitali Sinha: This is actually one of the earlier initiatives that we have supported and in Uganda there is something called the Uganda Health Information Network. And part of the primary focus of that work was to provide continuing medical education to nurses because nurses, at that point we looked at four districts and we did research to find out what was the benefit and the cost of having mobiles in the hands of nurses to be able to access this kind of information and what kind of influence that would have on the kind of health care that they can then offer. So that initiative has been underway for many years and now UHIN has been adopted as part of the country's national eHealth plan. Beyond that, in Rwanda, we are also supporting some work there to help nurses upgrade from a certain certification to another which can allow them to then carry out additional types of work and that comes back to the fact that there is a huge shortage like you mentioned.

Mark Masselli: Chaitali, you obviously keep track of what's happening around the world and we always like to ask our listeners to talk a little bit about what they see in terms of innovations though I think today it's fair to say all the projects that you have been talking about are innovative but what stands out for you and who should our listeners at Conversations be keeping an eye on?

Chaitali Sinha: What stands out to me is really this focus on enterprise architecture because it's kind of one of these things that needs to happen and in many countries Rwanda, Cambodia, Mozambique there is an amazing amount of work happening there that we are happy to be also part of. Zimbabwe is also on board now and the reason I say this is very innovative is because it doesn't discriminate in terms of what the issue is in terms of the health, it doesn't look at necessarily what the technology is. It can be radio it can be mobiles, it can be a mix of paper and computers and it's really taking that rather agnostic view that it's looking at the way in which health systems can be looked at from an aggregate point of view to understand not just the interactions within each health component or within each location but understanding what the relationships are across them. And this comes back to the whole movement towards a greater understanding of what are the health systems that work here. And to be able to stand up an enterprise architecture at a national level is incredibly powerful because not only are you able to visualize and show how all these pieces fit together but when you are able to build in those technical linkages to be able to share data across the health financing field and the HR and the medical record, all of a sudden you can see well you know what, we have this money, we could build new hospitals but you know what, we need more nurses, we need more doctors so perhaps we should invest in more education and then at the same time understanding how these things are influencing on other parts of the

system. So it becomes a tool to make decisions that are based on what is happening on the ground.

Margaret Flinter: Wonderful. Today, we have been speaking with Chaitali Sinha Program Officer on Research on health equity with the International Development Research Centre. Chaitali, thank you so much for joining us today.

Chaitali Sinha: Thank you very much for having me.

Mark Masselli: Each week Conversations highlights a bright idea about how to make wellness a part of our communities and everyday lives.

Margaret Flinter: This week's bright idea focuses on building support systems for children who are immigrants and refugees who often face mental health issues that affect their ability to learn and to adjust. The Tamaa program in Philadelphia was started 10 years ago, one of the early culturally specific therapeutic programs that recognized that these children have special needs. In 2001, the non-profit Children's Crisis and Treatment Center stated working with a large number of West African refugee children in West Philadelphia who were experiencing trauma-related symptoms along with trouble with acculturation and even bullying from their non-refugee peers in school. In response, the center created the Tamaa or Hope program designed as a school and community-based family centered program. Children participate in weekly group or individual sessions with trauma specialists and with mental health workers who are originally from West Africa. Parents and caregivers get help too and teachers receive specific training. Year-round community and multicultural events build support and awareness. A study conducted by the Agency for Healthcare Research and Quality or AHRQ found that the children in the program developed better coping skills, got better grades and showed an increase pride in their culture and based on this success, the program has gone on to train educators to become more knowledgeable about how to work with children affected by trauma. In 2006, the Robert Wood Johnson Foundation launched the Caring Across Communities program, a similar model to Tamaa now operating in 15 sites across the country benefiting children and communities from 55 different countries around the world. Developing a culturally appropriate approach to mental health that builds a community of support for population of children suffering from behavioral health issues and trauma, now that's a bright idea.

(Music)

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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