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

Margaret Flinter: And I am Margaret Flinter.

Mark Masselli: Margaret, I hope everyone had a fun and safe 4th of July, and one thing I would like to do is to read the Declaration of Independence which is found on the back of almost every newspaper printed in America on the 4th. And you know, I found out something that I hadn't realized that the last paragraph of the declaration was really the major driving force for the first 20 years after the declaration was written and that really declared that we were independent from England, and that's why we have those celebrations and fireworks. And obviously, it was a good time had by all.

Margaret Flinter: Well, I think it might be my favorite holiday of the year. And interestingly, I read the whole Declaration of Independence again myself and moved as I always am, last night got a little bit of the fireworks over New York and just the spectacle combined with the verse of the national anthem is always a very moving moment. It makes us very appreciative of what we have. And right here, closer to home, on the Friday before the 4th, we kicked it off with the start of the Farmers Market, now going on all over Connecticut, really focusing on making sure that all people have a chance at fresh fruits and vegetables, a chance to connect with farmers in our community and all in all quite a positive event and very much in keeping with the spirit.

Mark Masselli: It really was. And our members of Congress were doing the people's work in Washington, D.C. Their July 4th recess was canceled, and they are staying there because their president is really trying to craft a deal between the Senate and the House to raise the debt ceiling by August 2nd and that's the deadline when the U.S. Treasury could go into default if Congress doesn't raise the debt ceiling. I am worried about this date. It's a very complicated bill. We have been talking about it here. It's going to take a number of weeks to write it. And I think if we don't see some action in the next couple of weeks, we are going to be in trouble.

Margaret Flinter: Well, the debate continues and every day, there are certainly news articles on it. But the issues that we spoke about a few weeks ago really aren't any different now. The White House has identified at least $1.3 trillion in spending cuts over 10 years and is proposing up to $400 billion in new tax revenue. And just recently, President Obama said that the corporation should give up some tax breaks before the United States asks seniors to pay more for their Medicare benefits. But at the same time, he has signaled an openness to make change and spending reductions to Medicare. Meanwhile, Republicans are saying no tax increases and we want more spending cuts.

Mark Masselli: And thus, speaking of what other people were saying, the courts are now taking up the President's Health Reform Bill. I shouldn't say the

President's Health Reform Bill, it's America's Health Reform Bill. And the Appeals Court in the Sixth District became the first to rule affirmatively on the law. There are two other Court of Appeals who have heard arguments in May and June. But the Cincinnati Court said the law's requirement for most Americans to carry insurance or pay a penalty is constitutional.

Margaret Flinter: So out of Ohio, some very welcome news into Washington, D.C. for the administration. Now, looking at the larger picture of health policy, today we are very pleased to welcome Susan Dentzer, Editor-in-Chief of Health Affairs, the nation's leading journal on health policy. Health Affairs focuses on the intersection of health and health care and health policy in the United States and also around the world.

Mark Masselli: We are happy Susan can be with us today. But no matter what the story, you can hear all of our shows on our website Chcradio.com. You can subscribe to iTunes to get our show regularly downloaded. Or if you would like to hang on to every word and read a transcript of one of our shows, come visit us at our Chcradio.com site. If you are a social media aficionado, you can become a fan of Conservations on Health Care on Facebook and also follow us on Twitter.

Mark Masselli: And as always, if you have feedback, email us at Chcradio.com, we love to hear from you. And before we speak with Susan Dentzer, let's check in with our producer Loren Bonner for the Headline News.

Loren Bonner: I am Loren Bonner with this week's Headline News. With less than a month to go before the U.S. Treasury Department could go into default, if Congress doesn't raise the debt ceiling, President Obama discussed whether he could be open to accepting a deal with Republicans. Obama Administration officials are offering the cut tens of billions of dollars from Medicare and Medicaid and negotiations to reduce the federal budget deficit. But the depth of those cuts depends on whether Republicans are willing to accept any increases in tax revenues. On Tuesday, The New York Times reported that administration officials and Republican negotiators might take the money from health care providers like hospitals and nursing homes. This way, beneficiaries wouldn't be affected nor would there to be a need to restructure the Medicare and Medicaid programs.

A new study by a national health care group called Change Healthcare found that patients pay as much as 683% more for the same medical procedures in the same town, depending on which doctor they choose. Change Healthcare looked at claims data from May 2010 to May 2011 for thousands of employees of small businesses to determine price differences for several procedures like MRIs, CT scans and ultrasounds. The findings show that patients who pay for percentage of their care as opposed to a co-payment may end up spending much more for certain procedures than they would if they choose treatment somewhere else locally.

Mark Masselli: This is Conversations on Health Care. Today, we are speaking with Susan Dentzer, Editor-in-Chief of Health Affairs, nation's leading journal on health policy. Welcome, Susan.

Susan Dentzer: Great to be with you.

Mark Masselli: Susan, there are so many wonderful things to say about Health Affairs but every month, you offer expert thoughtful commentary on a range of important health care and health policy issues. In January 2010, Health Affairs redesigned, or should I say reinvented, itself in your timing nicely aligned with our country's renewed focus on Health Reform. It has been a boon for the growing audience of people **you are going** to be better informed. Can you share with us your vision on how Health Affairs fits into the broader discussion of health care and how you hope to shape these discussions?

Susan Dentzer: The tagline for our journal is that we are "at the intersection of health, health care and policy," and we take that very seriously. We think it's really important to be at that intersection and to be essentially a neutral party in communicating among the various entities in that intersection. Let me give you an example of what I mean. We know, for example, that if you look at what contributes to premature death in the United States, why do people die before their eventual life expectancy would tell you that they are likely to die, why do so many people have chronic illness and die at younger ages than others. And as we know we have a 33-year or more difference in life expectancy in this country, depending on who you are, what your racial and ethnic background is, what your level of educational attainment is or that of your parents' was, etc.

So if you ask why do some people die earlier than others, we know some of it has to do with your genetic predispositions but that's relatively speaking only 30% of the contribution probably. Your behavior has a lot more to do with it, whether you are eating right, exercising, etc. Your social circumstances have a big role. 15% or more of your likelihood that you will die early has to do with what is your status on life, what is your level of educational attainment or your overall socioeconomic level. And only relatively minor contributor to that whole equation is whether or not you have got adequate medical care.

So you put all of that in a big _____ 8:36 and what do you have, you have where we are born, who we are, what our education was, what our parents' education was, all of those things have as much, if not more, an impact on your actual health status than your health care. So it's very important to have a place where we talk about all of those things, what are the contributors to our overall level of health in this country, what is the role of health care in all of that, and what can we do with health care to maximize health given all the other things that contribute to our health and then very importantly, what should our policy be at the state, at the federal, at the local level to maximize our health because we

could all agree that what we really want is for our population to be as healthy as possible and therefore able to contribute to events in a society and really pursue life liberty and happiness.

Margaret Flinter: Certainly, the big goals of America, and let me ask you, Susan, that intersection between health care and health policy is pretty big intersection in and of itself but Health Affairs really goes beyond the U.S. health care system and U.S. health policy to look broadly on a global and international level. You have had many very fascinating articles looking at health care and Health Reform in other countries, certainly Great Britain, Switzerland, Spain, Germany and others. During the Health Reform debates, we often heard Americans want uniquely American solution but probably a lot for us to learn from other countries. What would you say are some of the key lessons that we could learn both from the health care system and the health policies in other countries?

Susan Dentzer: Well, it is certainly the case that the thing we have in common with people of other countries is we are all the people and obviously there are a number of things that stem from the fact that we all have essentially the same basic biology. And so that with respect to all the industrialized countries, the things that afflict us afflict them. So chronic illness, the fact that so many of us have cardiovascular disease are fighting overweight or obesity, have high blood pressure, the other factors that feed into cardiovascular disease and very importantly are battling cancers, those are universal across – first of all, across the world increasingly but certainly with respect to the industrialized countries.

So to the degree that other countries are trying to figure out how to develop health and health care systems that grapple with these chronic illnesses, these, they say, non-communicable illnesses, we just have a lot to learn with from other countries. Every industrialized country is struggling with how to do that well. When you have got people who are not acutely sick but are somewhat stick over a long period of time, you have essentially got to deal with them being in the community, getting up every day, going to work, not spending all your time inside a hospital. Thank goodness, we don't want that. But that sort of good structuring system that they can meet the needs of people in the community and actually keep them as healthy as possible and keep their chronic illnesses from getting worse and of course ideally preventing them, those are universal across all countries.

So there are lots of opportunities for us to look at how other countries are grappling with it. The other important thing is that all countries overall, but particularly the industrialized countries, are all struggling with the rising cost of health care and the fact that as they spend more and more on health care, to some degree, that threatens the inability to spend money on other things that they value. Now, it's true on the one hand that as countries get richer, they do tend to shift more and more money into health and health care. But it's also the

case that there is a tipping point with that, and we clearly have encountered that tipping point here in the United States.

Across the country, we have states where the budget and the state board, say, the Medicaid program or for other aspects of health care that are financed in part by the states are sort of crowding out the ability to spend the money that those states might want to spend more on the education. And I just finished saying that our level of education has a lot to do to contribute to our health. So we are kind of in this vicious cycle at this point in this country and other countries feel that they are getting close to that, too. So to the degree that other countries are figuring out ways to try to restrain the cost of health care or even lower the cost of health care, we have got some opportunities to learn from them as well.

Mark Masselli: Let's talk a little bit about some of those big challenges that you have laid out in terms of rising costs and limited resources here in the United States and our effort to improve our own health care system. Health Affairs has written about the unfinished business with the Affordable Care Act and as we know, the act has some hidden gems embedded within it and it also has some gaping holes. Can you share us with your thoughts on both of those?

Susan Dentzer: Yes. I think very much the unfinished business is what we are all really grappling with right now because despite what a lot of the pundits and pontificators say, you will frequently hear the statements made that the Affordable Care Act did nothing to restrain the rate of growth of health cost, that's really not accurate. What the Affordable Care Act did though was set up a series of very elaborate experiments that we can undertake to try to figure out how to restrain the rate of growth of health cost.

Now, the important point to make here is if we knew exactly how to do this and to do it in a way that was in sync with our other values, believe me we would have done it as Americans. So all of the struggle here is to figuring how we do this and how we get the other things that we want. For example, we obviously want innovation in health care, and we want better drugs, we want better devices. We don't want to much of that that we crowd out the spending on the things that we think will influence health in long run as I have just said.

So how do we have an environment where we have a lot of innovation in health care and health care products and services but we still have that at affordable cost? That's a really tough issue. How do we have what we want in terms of access to health care without breaking the **bank** and who decides – we know that this country reviles that the notion of rationing at the governmental level. Well, then what's the alternative if we are not going to ration at the governmental level overall? Again, if people had figured all of this out and could quantify it into law, believe me it would have been done.

So what the Affordable Care Act does is okay, let's set up some experiment of new kinds of systems that operate in a different way than we have operated our system so far, and let's see if those work. And some of those systems that now people are hearing a lot about are, for example, so-called accountable care organization. And what this really is is an attempt to create a health care delivery system that first of all is not paid the way our current system is paid. We pay health care providers nowadays mostly almost on the fee-for-service basis.

So every little thing that a doctor does, he builds separately for and you can imagine what this leads to as George Bernard Shaw once memorably said, "If you pay surgeons to chop off legs, each leg you are going to have a _____ 16:38 lots of amputees." It's just inherent in the process, even well meaning, they will just find reasons why it's probably in your best interest to have your legs at all. That's what fee for service does, it incentivizes volume. So we are looking at new way of paying system that doesn't do that.

The second thing we are doing is trying to figure out ways of rewarding health care delivery systems so they actually improve our health and so that these systems are rewarded because they improve our health or keep us healthy. Now, you would say, well why didn't we think of that before. Well, for various reasons, we structured a system what incentives do hospitals have, they have incentives to fill up their hospital beds and get paid. Wouldn't it be a wonderful thing if we had a system where hospitals were paid to keep themselves empty? Ideally, we want to keep people out of the hospital as much as possible, especially in the context of chronic illness. We want to keep you so healthy that you don't have to go into the hospital.

So figuring out a way to incentivize a health care delivery system to keep us as healthy as possible really becomes the name of the game. And so that's what the Affordable Care Act does. These are big important national experiments to figure out if we can try to create systems where we pay people to keep us healthy or as healthy as possible. Hopefully, we continue to incentivize innovation, and we do it in a way that distributes the care more equitably than we have historically because we are also giving coverage to the people who were previously uninsured. That's a pretty important set of experiments and that's the unfinished – that's the overall most important unfinished business of Health Reform.

Margaret Flinter: Great, and that's a very good overview of those issues. Susan, no surprise you probably we are both devoted readers of Health Affairs, and we certainly observe that you have really kept a spotlight on the issue of the need for transformation of primary care and examples of where primary care has been transformed. And almost from the beginning of the patient-centered medical home recognition programs and standards, we have seen a lot of focus on that. So as the editor-in-chief, I would like to ask you this question, is the transformation of primary care from your view a sweeping transformation across

the country or a slow crawl to a very uncertain outcome or somewhere in between at this point?

Susan Dentzer: I think it's probably closer at this point. Let's put it this way. To this date, it's been a slow crawl. I think the crawl is picking up a lot of momentum now because it is very, very clear, the evidence shows unequivocally that if you have systems of primary care that are really vibrant and very importantly well enough funded that can be vibrant, those systems produce better health and better health care and cost less, very important. And what we have done without intending to really in this country is we have let our primary care systems such as this, first of all, not become a non-system, a nonfunctional system and pretty much atrophy.

And why have we done this? Somebody is going to do some deep historical investigations someday and figure out how it happened, but I think briefly what happened is we put a lot of stock in very, very sophisticated, very advanced medicine. We structured the payment system that tends to reward that type of medicine, and we just forgot that we really need to pay people on the front end better than we do. And in particular because a lot of primary care is not intervention oriented, you know in a perfect world, your primary care doctor is saying things to you like, "You really have to have a very sensible and appropriate diet. You really have to exercise appropriately. You really cannot smoke." A lot of those prevention-oriented things, we either haven't paid primary care to do or we have paid them very poorly to do. And meanwhile, we pay extraordinarily high rates for people to get stents inserted in their hearts once they have serious heart blockages or what have you.

So we kind of have to chop the system back and say, "You know what, it really matters to have primary care people who are very, very confident and well compensated or compensated well enough that they can stay in business and make a go of it." And what we see now is a movement to, as you said, the so-called patient-centered medical home or as it's sometimes called in a way that **seems to scare** people less the advanced primary care practice. And that's where, in essence, you have individuals who have a very close relationship with a team of health care providers who are focused on their primary care.

It may or may not be led by a physician and may be led by a nurse practitioner. It could very frequently involve very intensive regular connections with not just nurses and nurse practitioners but also community health workers because goodness knows we have plenty of examples where sort of pure relationships with community health workers talking to people in their communities, helping them understand the importance of good diet and exercise. And if they have chronic illness, they being inherent to their medication regimens and things like that, sometimes just feeling with **the fear** is more effective in having people – have those kinds of behaviors than talking to a physician about it.

So we can put together teams like this, primary care team, that really work very closely with individuals in their communities to keep them as healthy as possible and to address whatever illnesses that they do have. And over time, if we make that investment, I think it's fairly clear that we can keep people healthier, the literature shows that, and that we will probably have cost savings at the end of the line as a consequence of doing this.

Margaret Flinter: Today, we have been speaking with Susan Dentzer, Editor-in-Chief of Health Affairs, the nation's leading journal on health policy. Susan, thank you so much for joining us today on Conversations.

Susan Dentzer: Great to be with you.

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

Margaret Flinter: This week's bright idea comes to us from Afghanistan where a new midwifery training program is making childbirth safer in a country with a second highest maternal and infant mortality rate in the world. The program was created by JHPIEGO, an international health organization affiliated with the Johns Hopkins University. This nonprofit has a track record empowering frontline health workers for almost four decades, and its efforts have improved health care for women and children in more than 140 countries worldwide.

Six years ago, JHPIEGO developed a plan to provide remote mountain villages in Afghanistan, often very far away from health clinics, with the resources that they needed to stop preventable deaths in childbirth. JHPIEGO has worked with Afghanistan's Ministry of Public Health to increase the number of village health clinics and to establish accredited midwifery schools in every province of the country. Now, young women can attend an 18-month midwifery training course in their provincial capital. And although women are not typically allowed to have jobs or travel alone in traditional Afghan society, a new system has been developed where village health counsels enable the community leaders to choose which women will receive the training based on their aptitude and interest and their relationship with the community. The women return as midwives to their villages, respected and ready to provide a full spectrum of prenatal delivery and postpartum health services.

While the presence of a midwife is a new experience for many Afghan mothers, most welcome the reassurance that these health workers provide. The percentage of deliveries attended by skilled birth attendance has increased from 8% in 2003 to 19% in 2006. By training midwives to provide the delivery, support and the infant care education that new mothers need, JHPIEGO is strengthening Afghanistan's health care system and improving maternal and infant survival rates across the country. Now, that's a bright idea.

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

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

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