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The American Health Care Paradox: Why Spending More is Getting Us Less

Mark Masselli:
This is Conversations on Healthcare. I'm Mark Masselli.

Margaret Flinter:
And I'm Margaret Flinter.

Mark Masselli:
Well, Margaret, there's a new person at the helm of the Department of Health and Human Services. Sylvia Mathews Burwell sailed with relative ease through the confirmation process receiving accolades from both sides of the aisle.

Margaret Flinter:
And she is taking over the helm from Kathleen Seblelius who resigned in the wake of the rocky rollout of the insurance exchanges. It's a daunting task that she faces. HHS has a trillion dollar budget, 80 thousand employees and they're really still in those first throes of the launch of the Affordable Care Act.

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

Margaret Flinter:
Most recently, she was the President's director of the Office of Management and Budget. Before that, she was president of the Wal-Mart Foundation, chief operating officer of the Bill and Melinda Gates Foundation and deputy chief of staff to President Bill Clinton, so obviously not stranger to high stress, high profile jobs.

Mark Masselli:
Analysts say she needs to hit the ground running. Former HH secretary, Mike Levitt, said her first priority should be to beef up relationships with states insurance commissioners, many of whom are still reeling from issues related to the first open enrollment and that she must act quickly to set standards in place for 2015 open enrollment, which technical speaking is just around the corner.

Margaret Flinter:
She really has to just imbue confidence in the department's ability to marshal its forces around the continued rollout of the Affordable Care Act. And there's still going to be some growing pains but she seems to have inspired confidence in some of the nation's top politicians, perhaps we could say top critics, and corporate entities thus far. So, I think her tenure holds promise.

Mark Masselli:
Outgoing secretary, Kathleen Seblelius, did spend some time recently thanking cohorts and supporters at the recent Health Datapalooza gathering in Washington. She lauded the distance they've traveled thus far in increasing health IT adoption through the nation's hospitals and health practices and the millions of newly insured Americans under the Affordable Care Act. She noted that HHS will continue to focus on reforms that optimize health outcomes and help us really reduce those costs.

Margaret Flinter:
That's something our guest today has spent a tremendous amount of her scholarly energy examining, Mark. Dr. Elizabeth Bradley is the director of the Yale Global Health Initiative and also the coauthor of the American Healthcare Paradox: Why Spending More is Getting

Us Less.

Mark Masselli:
She examines why healthcare costs are so expensive in this country and why outcomes still rank poorly compared to other industrialized countries. We'll also hear from Laurie Robertson, Managing Editor of FactCheck.org. But no matter what the topic, you can hear all of our shows by going to CHCRadio.com

Margaret Flinter:
As always, if you have comments please email us at CHCRadio.com or find us on Facebook or Twitter because we love hearing from you. We'll get to our interview with Dr. Elizabeth Bradley in just a moment.

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

Mariann O'Hare:
I'm Marianne O'Hare with these healthcare headlines. The Veterans Affairs healthcare scandal has done something that few other issues have achieved in this hyper partisan congress. Unite members of opposing parties in support of swift action to reduce veteran's rates for care and hold VA officials accountable for misrepresenting waiting times. The House overwhelmingly approved a bill that would allow veterans facing long waits for VA care to see private doctors, suspend VA bonuses and require an outside assessment. Early audits of over 40 VA facilities across the country shows the delay times and cover-ups were far more systemic than originally thought, with tens of thousands of vets possibly being forced to wait many months to be seen.

At this year's American Medical Association meeting, discussion was fierce surrounding yet again another failure by Congress to fix the sustainable growth rate formula that reimburses physicians for treating Medicare patients. There had been a bipartisan solution ready to sail through Congress but it wasn't acted upon in time, before the end of the session. Ire was so high over this in a long line of attempts to repeal the SGR that a decision was made to have an annual review of the AMA's lobbying efforts.

A number of trade groups and accountable care organizations have sent letters to HHS secretary elect, Sylvia Mathews Burwell, urging her to take swift action on improving impediments to implementation of telemedicine protocols such as remote patient monitoring and tele-health consults. Currently, tele-medicine is governed by a patchwork quilt of restrictions on use and payment models, which is in many cases hindering adoption. Those signing the letters come from across the spectrum. Qualcom, the American Tele Medicine Association, large ACO organizations like Geisinger. Secretary Burwell has the power to override some of those restrictions.

Want to keep that newborn on track for not developing asthma or allergies? Put away the antibacterial soap and heavy duty cleaners and let them crawl around in the muck. An eight year study of children from birth to several years show those kids exposed to cat and mouse dander, even cockroach dust had lower rates of asthma and other allergies by age three than their germ protected counterparts. The eight year study collect dust samples from the homes of newborns and tracked that data over the length of the study. Results are somewhat counterintuitive considering the highest rates of asthma and allergies are among kids growing up in urban environments awash in such allergens. It's the latest wrinkle in the hygiene hypothesis. The notion that exposure to bacteria trans the infant immune system to attack bad bugs and ignore harmless things like pollen and cat dander.

I'm Marianne O'Hare with the healthcare headlines.

Mark Masselli:
We're speaking today with Dr. Elizabeth Bradley, Director of the Yale Global Health Initiative and Faculty Director of the Global Health Leadership Institute. She's coauthor of the book The American Healthcare Paradox: Why Spending More is Getting Us Less, which examines reasons for America's extremely high health cost and relatively poor outcomes. Dr. Bradley's a professor of public health policy at Yale School of Public Health. She's earned her bachelor's at Harvard, her MBA at the University of Chicago and her PhD at Yale. Dr. Bradley, welcome to Conversations on Healthcare.

Dr. Elizabeth Bradley:
Thank you so much, Mark.

Mark Masselli:
It's a great book, first of all. It's a wonderful read, The American Healthcare Paradox. You explore how much we're spending per capita on healthcare in this country and how we rank relative to other industrialized nations in terms of outcomes. The subtitle of your book is Why Spending More is Getting Us Less, suggests that we're not doing as well as we could. Your focus at Yale is on Global Health Initiatives so you're well positioned to comment on which country has the best healthcare system in the world. So, can you explain to our listeners the paradox and help us understand how we actually stack up relative to other countries around the world?

Dr. Elizabeth Bradley:
The paradox in the American healthcare system is as you said, we spend about one-and-a-half times to two times as much per capita as any other country in the world, and yet our health outcomes are among some of the worst. Actually, for instance, our maternal mortality rate is six times that of Sweden. Our life expectancy is six years less than the best country's life expectancy is. These differences, these disparities go on and on across diabetes, heart disease, teenage pregnancy. It goes on and on. So, that's a paradox. How could we spend so much and get so little. We do however get something for that. Of course, we do have tremendous access to high technology equipment, kidney transplants, knee replacements, etcetera, some of those very, very technical pieces. But when you look overall to the big health outcomes we're just not doing as well as countries that actually spend less than we do.

Margaret Flinter:
So to do this work, Betsy, you took a deep dive all around the world and examined health data from some 30 countries and you came to this conclusion that while we spend close to 20 percent of our GDP on healthcare in the United States and I think that's roughly three trillion dollars per year, we're spending far less than other countries on social services, which goes a long way in those countries to improving population health. They do that, of course, by heading off problems early. Can you give us some examples of how other countries are offsetting healthcare costs by investing in social programs on the front end?

Dr. Elizabeth Bradley:
Maybe I'll just give one statistic that puts this in frame. For every one dollar the United States spends on healthcare we spend another 90 cents on social services. But in Western Europe for every one dollar spent on healthcare another two dollars is spent on social services. So although we're all spending about the same amount of the total GDP when you look at both of these together, we just favor heavily the medical care and the healthcare side and we're less favorable on the social service side. Education, housing, transportation, nutrition, rehabilitation. Now what do other countries do? How do they do this differently? The place that we were most impressed with is really spending a moderate amount of money and getting the best health outcomes as Scandinavia.

We wanted to go there to understand what could we learn. We know we can't do the identical same thing. We're much bigger, we're much more diverse, we have different history, different relationship to our government. But is there any mechanism they're using that we could learn something from. One of their clever ways in which they deal with this is at a county level they do joint budgeting and planning for all the social services and the medical care services. So, it is actually done in an integrative way. Somebody in the county government could say we're going to put a little more in housing then we won't have to spend quite so much money in the emergency room. It's the same system that benefits from that offset, which we really don't have in the United States. We don't have a local government area in which we can do that joint planning. Really, one side would benefit from the other side and vice versa, sort of as one system to try to use our scarce dollars to make the greatest health outcome we possibly could.

Mark Masselli:
It seems to me to be another one of the paradoxes that everybody is talking about, the social determinants of health but we don't see a lot of real activity happening on the ground, as you're suggesting. You had the opportunity to sit with a whole gaggle of thought leaders for your book who figured out the formula. Can you highlight some of those organizations that are really improving care on that front end? The support services and what sort of healthcare savings on the backend have been achieved, if any, as yet.

Dr. Elizabeth Bradley:
It's interesting because we found these sort of homegrown innovations in the United States across diverse sectors. I mean they were in private sector, public sector, sometimes they were really driven by the healthcare providers. Sometimes they were really driven by local government. I think even we will start to see more and more driven by the employer base. One of the learnings for us is just echoing our country's way, we're extremely diverse and we saw many different small level innovations. Our big challenge in the United States always is how do you take a good idea like that and scale it across such a diverse country so we can really multiply the effect of the innovation. A couple of programs I would turn to. One is in Portland, Oregon called cTRAIN and it's a collaboration between the Oregon Health and Science University, a very large academic medical center, and Central City Concern, which is a community center. The community center almost acts as the hinge between what is a high-tech medical care system and what is really housing immigration support, legal support, education, nutrition, cooking support, exercise.

What the Oregon group did was they established a joint governance structure in which the hospital and health system actually provided support to the Central City Concern by placing and guaranteeing slots with primary care coordinators basically in the central city. Any patient that was at risk for really post-discharge readmission or having intense social service needs they identified early. The put them on the cTRAIN and they got the full case management. Then this community center really was engaged and helped them be sure that they could access services that were already paid for. Often, the hospitals may not even realize or have the energy and the resources to connect people in. But if you can just get the connection the resource is there and sometimes underutilized.

The other piece we saw in this is when the healthcare system, when it got involved with some of these community, state and local social services there was an automatic we're going to track things now. We're paying attention. There was a certain, I think, rigor that came to the management of both of these kinds of services to make them both better. They did a randomized trial. They found their patients had lower mortality, better quality of care and the hospital is actually funding expansion to offer this service to even their high income and donor population that's coming in as patients.

Margaret Flinter:
Betsy, when we talk about health and healthcare and social spending we're inevitably going to talk a little bit about politics or the political climate. Not too long ago, the food programs were cut by billions of dollars and that's just one example of many that really goes against what your findings are. What are your thoughts about the kinds of political incentives that might be deployed to improve social program spending, specifically as a hedge against high healthcare costs? Tell us about that and also the degree to which you think the Affordable Care Act addressed any of these issues along with the issue of un-insurance.

Dr. Elizabeth Bradley:
I think the first thing that is an important implication of our book is not that we need to spend more in the social service area. As you said, in this political climate in the United States with our history, that is really very unlikely, I think. However, the idea really in the book is can we use, as you intimated the healthcare dollar, which is, as you said, almost 20 percent of our GDP. Can we use that significant investment and make it in the best interest of those providers who also address some of the social determinants of health and get involved with the services that are already funded at the state level. We do have to think very closely about incentives, as other authors and policymakers have really underscored. Our incentives now are still, for the most part, to provide more medical care. That's an incentive from the supply side. Physicians and hospitals do better financially from that but also from the demand side. Patients and families, we see ourselves as needing medicine and that's a whole other thing that's quite different in the United States from, for instance, Scandinavia.

From both sides we have an incentive system that asks us and pushes us to put more and more in medical care. How to redirect that? I think the ACA does hold some potential for us. My fear is that we may not go far enough with this and it may, nonetheless, become very medicalized, but it does create a platform on which providers can collaborate. They can take a set pot of money for a group, a population and they can be held accountable for some of the health indicators, not just the healthcare indicators. That is possible. It would be legal. It's regulatory supported through the ACA. However, in the early rollout of the ACA most of the indicators on which these provider groups getting together are being evaluated on are still not health indicators. They're still services. So we haven't yet gone to the place or they're very much in nascent effort where the organization is actually rewarded for what percent of their patients are obsess, what percent of their patients are housed, what percentage of their high school patients are on track to finish high school. This would be an extreme forwardness and I think it will be decades before we think this way. Thinking a little bit more holistically about all the things that can make their patients healthy, not just medical care.

Mark Masselli:
We're speaking today with Dr. Elizabeth Bradley, Director of the Yale Global Health Initiative. She is coauthor of the book The American Healthcare Paradox: Why Spending More is Getting Us Less. We're spending a lot of money. We're spending one out of five dollars or 20 percent of the GDP. We're just coming out of a terrible depression, recession, however you want to label it and so what's the concern about the diminution of health spending? You've got part of it is you're going to shift some of those dollars but there's a big drive in this country to reduce cost. Is that going to unravel all of these initiatives if we start to undermine the economic underpinnings of the country in some ways by starting to reduce cost? What are your thoughts on that?

Dr. Elizabeth Bradley:
It is a razor's edge really between people who have to pay the cost, employers who can't pay the cost anymore and therefore they can't be competitive so that hurts our economy. Or we're going to save money on healthcare and so now everybody who is actually employed in the healthcare sector, we're looking at a very large part of our industrial growth. One thing we might look at is maybe we're spending about what's right but we haven't really thought through how to spend it as efficiently as we can, allocating it in a way that truly will get us this spending but a much healthier population. That would be the goal.

Margaret Flinter:
Betsy, I think the book is all about Paradox and also conundrums I guess I would say. Let's turn to the ACO just to get all of our alphabets in there in the accountable care organizations, which are generally described as organizations of grouped providers that hopefully more effectively coordinate healthcare for large populations of patients. How effective have these organizations been at improving health outcomes for their populations while seeking to contain costs? What are your thoughts on that?

Dr. Elizabeth Bradley:

The accountable care organizations, the evidence on their impact is very mixed. You would never look at the body of evidence coming out of our last three, four, five years of experimentation on this and say that is going to transform healthcare. You just wouldn't. On the margin, with the right case management model and the proper navigation model in the right communities they're finding modest savings. So, that's just not something that I think we can hang our hat on assume that's finally going to get us out of this conundrum as you said. It draws much deeper than just reorganizing the deck chairs on the Titanic really. How do we, as a public...how do our communities first understand health? What do we demand when we have a hurt back? What do we want when we hurt our shoulder? In the American world, a lot of what the first thing happens is try to get in line for an orthopedic who will get you to an MRI who will likely land in surgery.

We have story after story in the book of places where people chose a different path to try to look at a more holistic, more behaviorally focused way to deal with that pain they may have in their shoulder. But that concept of how the community understands what healthcare can do for it, that's really core to solving and addressing this problem. It's going to be pretty hard, I think, to put aside our self-interest in whichever side of this industry we're in and really look at health. That's collective good but how to get a governance structure around that where people can really collaborate.

Mark Masselli:
Dr. Bradley, I want to talk a little bit about the American solution. You focused a lot on the Scandinavian countries, Norway and Sweden. Tell us about those and the challenge of cross walking those over to our unique culture here.

Dr. Elizabeth Bradley:
Yeah. Well, I think the challenges of really cross walking some of what we've learned in Scandinavia to the United States has a lot to do with what our face is in our government and what we would delegate to our government to do. That's one piece of it. We use the World Values Survey to compare the United States to Scandinavia. That basically characterizes people's rude values about what they feel about their government income in a quality whole set of measures, one of which is trust. Scandinavians are very high on trust and Americans not so much. But we have some huge assets in the United States that are not anywhere else. We have a tremendous amount of innovation and localism. When you get into the local, local communities amazing things are happening like the cTRAIN. But we saw things throughout the country that were at a very local level where trust is high. That I think, unlike perhaps Scandinavia, our pace of change is very fast. Our freedom to make a new idea is very fast ____ (21.36) a local homogeneous community we're pretty good.

So, I think in some ways we may come up with more innovative things than we see around the globe. That's what we really ought to be looking at and even at the employer level. I mean we have some tremendous things that employers are starting to think about and experiment with that I think you wouldn't see that kind of experimentation in other countries.

Margaret Flinter:
Betsy, I want to continue that move from the global to the local. I read your analysis and your thoughts on the community health center movement. Over time, legislation, funding initiatives all well intended had perhaps an unanticipated consequence of shifting the focus back much more heavily to investment in the healthcare part of it and less in addressing the social determinants. Food, housing, safety of the environment and what a loss that's been. I wonder, if you'd like, this would just be in the opinion category, do you think that the community health center movement, 20 million patients expected to grow to 40 million all across the country has the potential to be one of these local community-based and very diverse communities strategies for beginning to shift some of that investment from healthcare to social services?

Dr. Elizabeth Bradley:
Yes. I absolutely think it is central, huge potential. There are a couple of pieces that I think have to fall into place to get that locus to really flourish looking at the social determinants. What happened in the early days in the '60s that really shifted things was putting the community health center movement, allowing its revenue stream to be fully dependent on Medicaid and Medicare, which could only pay for medical care things. When that happened, it changed the incentive system, it changed the psyche. Not of the people but just of what really was possible within organizational constraints. Today, we may see a loosening of that. It's possible, I don't how far the country will go but states are starting to be quite innovative with their Medicaid programs. There are a lot more waivers that can happen for dual eligible or for Medicaid only recipients in which the dollar could be used to do the combination that a community health center might tell you is going to be the most effective. Not only the medical care, not only the referral to the hospital but potentially looking at housing.

I call our attention to this 10th Decile Project in LA, which worked with hospitals to identify the top 10 percent of homeless people and basically used Medicaid dollars to work on the homelessness and other social support services through community centers first before the referral to hospital. They just had tremendous savings. I mean it's only been a couple years. But they are quoting healthcare costs decreasing by 72 percent. So I feel like the provider group of community health centers is exactly where it could be but we do need the payer piece of it to align with health, not healthcare in order to allow these centers to really flourish in what their vision has always been.

Mark Masselli:
We've been speaking with Dr. Elizabeth Bradley, Director of the Yale Global Health Initiative and Faculty Director of the Global Health Leadership Institute. She's coauthor of the book The American Healthcare Paradox: Why Spending More is Getting Us Less. You can learn more about her work by going to GHLI.Yale.edu. Or you can follow her on Twitter @EHBYale. Betsy, thank you so much for joining us on Conversations.

Dr. Elizabeth Bradley:
Thank you, both.

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

Laurie Robertson:
Well, did the Affordable Care Act increase income tax brackets, capital gains and estate taxes in 2014? That's what a viral email says but it's not true. The anonymous message claims that several taxes went up on January 1, 2014 because of the Affordable Care Act but none of the taxes listed had anything to do with the healthcare law. Most were part of the fiscal cliff package that Congress passed on January 1, 2013. For instance, the top income tax rate did go back up to 39.6 percent for singles making more than 400 thousand dollars a year and couples earning more than 450 thousand dollars. That increase was part of the fiscal cliff deal in 2013.

Capital gains and dividend tax rates also went up under that deal and not as much as the viral message claims. The top capital gains rate and dividend rates are both now 20 percent for those earning more than 400 thousand or 450 thousand a year. The email wrongly says that the estate tax went from zero percent to 55 percent. The tax is still zero percent for anyone who dies this year and has an estate worth less than 5.3 million dollars. The top rate is, thanks to the fiscal cliff deal, 40 percent.

This message goes on to claim that the tax increases it lists were "passed with only democratic votes." Not true at all. The fiscal cliff deal passed by a vote of 89 to eight in the Senate with 40 Republicans in favor. In the House, 85 Republicans voted in favor.

The ACA does include some tax increases, such as a 3.8 percent tax on net investment income and an additional Medicare tax of 0.9 percent for those earning more than 200 thousand dollars a year or 250 thousand dollars for couples. But that increase is nowhere to be found in this bogus viral message. That's my fact check for this week. I'm Laurie 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 Laurie Robertson check it out for you here on Conversations on Healthcare.

Each week, Conversations highlights a bright idea about how to make wellness a part of our communities and everyday lives. Primary care providers have their work cut out when seeing patient after patient all day long. In brief visits it can be difficult to cover all of the important bases. Often, signs of drug and alcohol dependence can get overlooked and many patients are put off by lengthy questionnaires that are aimed at determining whether you have a problem with drinking or using drugs. Researchers at the Boston University School of Public Health have determined that asking one simple question could actually determine the level of a patient's possible drug or alcohol dependency.

For alcohol use participants were asked how many times in the past year they had consumed five or more drinks in a day. For other substance use they were asked how many times in the past year have you used an illegal drug or used a prescription medication for nonmedical reasons? The researchers compared alcohol screening responses with alcohol dependence reference standards and drug screening questions with drug dependence standards. The single alcohol screening question detected 88 percent of those with alcohol dependence. The drug question detected 97 percent of those with drug dependence.

Lead researcher, Dr. Richard ____ (29.18) says this could provide a valuable rapid assessment for primary care providers to help patients and get them to the treatment options they need. A single, simple question aimed at revealing drug or alcohol dependency that could help primary care providers diagnose the problem more readily, getting patients sooner to the help they need. Now, that's a bright idea.

This is Conversations on Healthcare. I'm Margaret Flinter.

Mark Masselli:
And I'm Mark Masselli. Peace and health.

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