Mark Masselli: This is Conversations on Health Care, I'm Mark Masselli.

Margaret Flinter: I'm Margaret Flinter.

Mark Masselli: Well Margaret some positive news on the opioid front according to a recently released dataset prescriptions for opioid pain killers drop significantly last year declining by more than 10% in 2017.

Margaret Flinter: Well it's dramatic really shift in clinical practice, not only were fewer prescriptions written overall but the number of first time opioid prescriptions dropped by around 9%. I have to wonder Mark is that also consumer saying no way I've heard too much about this and don't want them.

Mark Masselli: This comes on the heels of a policy directive two years ago for the Centers for Disease Control and Prevention which issued much more stringent guidelines for opioid prescribing it. It seems they've had an impact Margaret.

Margaret Flinter: Of course that's really how the crisis began, certainly well meaning clinicians who are just seeking to help their patients manage their pain. These guidelines and this very actionable data are critically important tools to get a handle on this public health crisis or any public health crisis but especially one that is as widespread and as deadly as this one has been.

Mark Masselli: Speaking of actionable data, that leads us to our guest today Dr. Ashish Jha is professor of medicine and global health at Harvard Medical School. He just released a comprehensive analysis of American health care cost that confirm some notions about why American health care cost so much more than other countries.

Margaret Flinter: He is also going to talk with us a little bit about a shocking lack of relevant data to be able to effectively study and analyze the cost drivers in American health care, so we're really looking forward to hearing his insights Mark.

Mark Masselli: We're also looking forward to Lori Robertson the Managing Editor of FactCheck.org. You can hear all of our shows by going to chcradio.com or iTunes.

Margaret Flinter: As always if you have comments please email us at chcradio@chc1.com or find us on Facebook or Twitter. We'll get to our interview with Dr. Ashish Jha in just a moment.

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

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Marianne O'Hare: I'm Marianne O'Hare with these health care headlines. The president's pick to replace fired VA Secretary Dr. David Shulkin is getting some pushback. The Senate Veterans Affairs Committee is holding up the nomination saying some new information has come to life including the nominee presiding over a quote, "Hostile work environment and overprescribing drugs." Members of both sides of the aisle concerned about these new revelations.

That scope they're using to pier into your oesophagus chances are pretty good it's contaminated, infection control has become a top priority and safety concern, but a study of reusable scopes in several major hospitals showed 71% of them were contaminated with some form of bacteria. The study found the presence of bacteria not just in the bulk of endoscopes but scopes used for lung and kidney procedures as well as colonoscopies. The researchers observe some sloppy handling and lack of adherence to disinfecting protocols throughout the study.

Donated livers are precious and hard to come by for transplants, currently roughly 17,000 Americans are on a waiting list for a deceased person's liver. Then there's a transport, the usual mode of liver transport was a typical Coleman like cooler and a pack of ice. Study of new transport method in a carrier design to mimic the body temperature and function keeping the organs quote, "Breathing" actually yielded two positive results. The organ stayed healthier for a longer period of time and the process allowed previously inferior livers to be rendered transplant worthy. This is promising news for those in the agonizing weight for donated liver. I'm Marianne O'Hare with these health care headlines.

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Margaret Flinter: We're speaking today with Dr. Ashish Jha Professor of Medicine and Global Health at Harvard Medical School and Senior Associate Dean for Research Translation and Global Strategy at Harvard T. H. Chan School of Public Health. He's also Director of the Harvard Global Health Institute. He's a member of the National Academies of Sciences, Engineering and Medicine, he earned his medical degree from Harvard Medical School. He completed his training at Brigham and Women's Hospital and received his master's in public health from Harvard T. H. Chan School of Public Health, Dr. Jha welcome back to Conversations on Health Care.

Dr. Ashish Jha: Thanks for having me I'm excited to be here.

Mark Masselli: I think it's axiomatic for most people that when you say the American health care system it's the most expensive in the world. You recently released a detailed report that's getting a lot of attention, you compared the health expenditures here in the United States to 10 other industrialized nations. I'm wondering if you could

share with our listeners what you set out to achieve with the study and what you found most surprising.

Dr. Ashish Jha: Everybody knows American health care about twice as expensive as other high income countries. There are lots of theories about why that is. When we lack data on a topic, then stories and theories really end up kind of dominating the public scene. If we're going to make progress on spending in America we have to actually understand what's behind our cost problem. There'd been some really good work back in the late 90s by Uwe Reinhardt and Jerry Anderson that was entitled It's The Prices, Stupid. The ideas behind that paper was that it was really prices in health care that were the drivers, and its international comparisons have been hard because without comparable data it's very hard to compare apples to apples. The good news is in the last five, seven years there's been a lot of efforts to put together information that really puts countries on an equal footing and said hey, let's understand what's going on between these different health systems.

Margaret Flinter: Well Dr. Jha we really are curious as you have pursed out the many hidden cost that go into health care. What did you find when we come to those details of the hidden cost?

Dr. Ashish Jha: Yeah so if you look at American health care and you compare it to these 10 other countries all among the highest income countries sort of Sweden and Japan and Denmark. The most predictable finding is our administrative cost are about two to three times higher than almost any other country. Just the common theories that we have about American health care, one of them is people often say they were very specialty driven, the European countries are very primary care focused. It turns out not so much, like when you look at the proportion of doctors in America that are primary care it's a above average across all these countries, we're really not an outlier on primary care.

Another very commonly held belief has been that we have this problem with overutilization that we just do too much [inaudible 00:07:07] people, people spend too much time getting major surgeries. Then it turns out we use hospitals a little bit less than average compare to these other countries, we do more MRIs and CPs, we have more knee replacements but we have fewer hip replacements. We were above average on a few utilization below average on a few others, and then we're pretty average. A lot of these basic theories that we've had turn out none of those are all that different between America and Europe, the big difference is prices. Again in some ways it comes back to Uwe who was one of my heroes and has taught us more about health care than maybe anybody else. It really turns out that the same medicine in America cost three times as much as the medicine in France. It's not about utilization, it's not about primary care, it's really about how much we pay for everything.

Mark Masselli: Well speaking of sort of European countries in primary care we just had doctor Charles Alessi on as guest Senior Advisor for Public Health England who talked about UK's ability provide access to primary care for all citizens without the barriers of having to pay services at the point of care. I wonder if you could give us some examples of some of the other health systems you studied and how their delivery system factored into lower cost but better outcomes, what did you find?

Dr. Ashish Jha: Yes we looked at Sweden and Denmark, Japan, Canada, UK. One of the big points, there is no European health system, Switzerland was very different from the UK which looks very different from France. It's true that there's no payment at the point of service for primary care in the UK, things look different in Switzerland. It's true that there are a lot of primary care physicians in Denmark, Sweden has far fewer primary care physicians. What it tells us is every country arrives at its own solution for providing good care, for covering everybody. If America is going to make progress it's not going to make progress by copying Germany or France or England. It's going to make progress by coming up with the uniquely American solution.

Margaret Flinter: Well Dr. Jha we've also been following your work on analyzing the effectiveness of some of the new payment models that have emerged in recent years. We now have a growing number of accountable care organizations and interestingly they are across the commercial world, the Medicare world and even the Medicaid world, and those organizations are collecting data on cost savings and improved outcomes. We're really curious to hear your thoughts about which of alternative payment models you think hold the most promise that you think would really sort of advance progress further?

Dr. Ashish Jha: Look, I am a big believer in alternative payment models, but one of the things I like is how people – it's a faith based initiatives, we do not have much evidence that they do very much. I think we have to be circumspect, it's been eight years since the passage of the Affordable Care Act, I would say the overwhelming evidence is that value base payments, fee for performance, giving bonuses and penalties, but that has been a complete failure, has not move the needle. Almost all the evidence said that it has probably hurt safety net providers, but other than that it has not improve quality for almost anybody. If you try something with good intentions and it doesn't work they got to stop. We have a very hard time in our country stopping polices that are not working, and I think – I don't know how much longer you want to give it but we've had a decade of experience.

On ACOs and bundled payments I am more hopeful, but that hope is not based on a whole lot of very strong data. On ACOs the net, net is that they've probably have saved us a little bit of money, so I'm aware around 1 or 2% lower spending. Not that they reduce spending by 1 or 2% but it has grown about 1 to 2% more slowly than

comparable organizations that were not part of ACOs. Not a home run, quality maybe marginal improvement and outcomes, bundle payments is a bit in the same story, maybe the savings are a little bit bigger, no impact on quality as far as I can see it. What we need to do is keep experimenting with these models, try bundles with more things, try longer bundles with ACOs, try right now some pretty much one sided risk. Maybe once we move organizations into two sided risk we'll see more movement. My general take is as long as we got experiment and when experiments don't work we got to stop.

Mark Masselli: We're speaking today with Dr. Ashish Jha Professor of Medicine and Global Health at Harvard Medical School, and Senior Associate Dean for Research Translation and Global Strategy at the Harvard T. H. Chan School of Public Health. I was thinking as you are talking about, there's no country known as Europe, and I'm wondering if there's really a country called America because there are really 50 states right, there are 50 Medicaid programs, there are 50 health insurance commissioners, many other thing you are talking about is prices and had Steven Brill on the show. You can't get to prices, prices are high but I can't understand them, how do we sort of address that in this larger context to finding this American solution?

Dr. Ashish Jha: People love talking about Finland and how great Finland is. Finland is 20% smaller than Massachusetts, and to compare Finland to America doesn't actually make – [Crosstalk]

Mark Masselli: Doesn't work.

Dr. Ashish Jha: What's interesting is in our paper we showed some data looking at for instance, Minnesota. Turns out Minnesota's health spending and health outcome look exactly like Sweden, on spending it's still higher than Sweden but on health outcomes Minnesota is Sweden. My take on this is we have Massachusetts and Hawaii, but we also have Mississippi and Alabama and places that don't have much higher rates of poverty. If we're going to think about America as a country which I would like to, we have to first begin by understanding its complexities and the right comparison Denmark as Bernie Sanders like to say, but the right comparison may in fact be Europe because Europe is about the size of America and has a diversity.

One of the things we talk about is how do we get the universal coverage in America. Well Massachusetts is at about 98, 99% coverage, I mean we're close. As a nation we're at 90%, that's not bad, we've got to figure out a strategy for getting the other 10%. The Affordable Care Act try to do that, we can get to an American solution on this. Letting states have a good amount of flexibility for how they get the full coverage, but basically demanding the states figure out how to get the universal coverage within their own population. Some states will do it through Medicaid other will push on exchanges.

One the issue of prices, there are two ways that people know how to control prices one is really efficient markets, lots of competition so that if you charge high prices your consumers will go elsewhere.

The second approach of course is a very strong price set up that says we're spending only 300 bucks on an MRI you want to charge a thousand you can, well if they're going to get 300 it's not a penny more. We have figured out how to do the worst of both world, we have in Medicare a very week price setter that's politically constrains from dealing with prices. Most markets have a lot of market power and providers who can charge very high prices, but doing neither which is what we're doing now I'm thinking that ACOs and bundle payments will somehow solve our cost problem, it's not going to get us there.

Margaret Flinter: Well Dr. Jha let's talk about the consumer or we can call the patients. The reality seems to be that consumers are facing much higher co-pays and much higher out-of-pocket cost which perhaps causes them to think twice before utilizing some health care services. When you look at this issue, what role does consumer spending playing in the overall health cost as people have to really make decisions with their pocketbook about what they're going to actually spend money on, what hope might there be for a better focus on primary of prevention?

Dr. Ashish Jha: No doubt, we've gotten a lot more people covered, but the cost for that coverage has been 60 million Americans now have a relatively high deductable health plan. If you're wealthy it's no big deal, but for average Americans it's a real financial burden. The data is very clear, when you go into a deductable health plan you have large co-pays, large deductibles. What happens is you can do fewer health care service, now of course that's the whole goal, right, the data says that you consume less of unnecessary stuff that's good, you also consume less of necessary stuff, so people are not able to make rational choices of when they face very high deductibles. I actually think it's because it's hard to make those decisions, I put my family in a high deductible health plans. Of course as a physician and above average income I found it a struggle, I made some really bad decisions.

Look, we are doing it half way where we're really kind of picking the worst of both worlds, because if you [inaudible 00:16:05] deductible health plan can it work to improve quality ad improve spending? It can, but it needs a few other things, it needs real price transparency, it needs the opportunity for other low cost providers to come into the market and making – pay for out-of-pocket all it does is a shifts the bill to me instead of the insurance company. What we need to have is a lot more innovation and competition in the market place, if we're going to give [inaudible 00:16:28] to the health plans and experiment, got chance to work, otherwise all we've done is just made life harder for middle income Americans not really fixing the underline problem.

Mark Masselli: I love your quote that an ounce of data is worth a thousand pounds of opinion. I think it's going to be right up there with Mart Twain's there are three types of lies, lies, damned lies, and statistics. You say research has been and continues be hamstrung by the lack of truly actionable data of cost such as provider salary, the amount of money been spend on low value care. You say that we have a treasure trophy of Medicare data that could provide quite useful information to us, and I thought our friend Todd Park had liberated all of that data. I'm wondering if you could talk about the lack of access to actionable data and why this access is so important to moving the needle in the American health care system.

Dr. Ashish Jha: Yeah, it's little bit of a world view thing. I mean I look at the last 100 years of human history and I think, boy we have massive progress how we make so much progress in the last 100 years. If you think about almost all of the big games that have come from research, from public health, from health care discoveries and so I just have this very strongly held belief that if we can study questions, use real data, real evidence we can make progress on almost any topic in front of us. Then when we go to the American health care system, right, which is three plus trillion dollars, it's sucking money away from education and social services, companies and households. If I say okay I want to figure out how to make this health system more efficient. I can come up with theories, but if we're going to use evidence which I believe is the only way we're actually going to make progress, we need data.

Todd Park and others have been evangelicals on this, but here is the reality on the ground. In 2018 I as a researcher every year that I want Medicare data to answer any set of questions like our ACO saving money. I have to show out about a 150,000 dollars a year, that's how much money I have to spend at a Medicare to give me a standard cut of data, and so guess what, there are only five or seven research groups in the country that actually were able to afford getting this kind of data every year. Medicare should give this data away for free. Get a hundred research groups working on this, a thousand research groups, and what you'll get is a lot more interesting, there's a lot more data, and a lot more learning about how we're going to improve health care.

The approach right now were basically only a small numbers of groups can do this because the data is so hard to get. I'm still waiting for 2016 data, I haven't received the 2016 data yet. Imagine if the fed made interest rate policy based on data from two years ago, no like they're making it based on job market data from last week. I'm sorry, with all due respect to folks who have been on this and I appreciate what they've been trying to do, we have not liberate yet, not anywhere close.

Margaret Flinter: Well we want to throw our support behind the liberation forces for that Medicare data so well, thank you for making that point. We've been speaking today with Dr. Ashish Jha Professor of Medicine and Global Health at Harvard Medical School

and Senior Associate Dean for Research Translation and Global Strategy at the Harvard T. H. Chan School of Public Health. You can learn more about the study and Dr. Jha's work by going to HSPH.Harvard.EDU/Ashish.Jha or you can follow him on Twitter @Ashish K. Jha. Dr. Jha thank you so much for your body of very important work and for joining us again on Conversations on Health Care.

Dr. Ashish Jha: I always enjoy sitting with you guys 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: This week we'll turn to the public health issue of guns. Our readers asked us if the Obama Administration had legalized bump stocks for semi-automatic rifles, as President Trump claimed in a tweet. Well no federal law explicitly addresses bump stocks. The Bureau of Alcohol, Tobacco, Firearms and Explosives will 10 times between 2008 and 2017 but certain models could not be prohibited under existing gun laws. A bump stock is a device that can be attached to the rear of the semi-automatic rifle to make it shoot almost as fast as a fully automatic weapon. The device has became part of the gun debate in October after 64 year old Stephen Paddock used AR style rifles fixed with bump stocks to shoot people attending an outdoor concert in Las Vegas killing more than 50 people. That issue is whether the devices meet the definition of machine gun under federal firearm laws which have prohibited the transfer and possession of a machine gun since 1986. Federal law defines a machine gun as a weapon that quote, "Is design to shoot, to shoot automatically more than one shot." It's true that under Obama the ATS an agency within the Justice Department ruled that it could not prevent the use of certain models of bump stocks , but it also made a similar ruling in April 2017 under the Trump Administration. Some bump stocks have been deemed illegal for just the Akins Accelerator in a 2006 ruling because it was determined to meet the single pull of the trigger definition of a machine gun. The ATS in the late March proposed a rule to clarify that a machine gun does include bump stocks type devices. Gun rights groups and advocates however had said that any final rule could be challenged in court. 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 Healthcare.

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Mark Masselli: Each week Conversations highlights a bright idea about how to make wellness a part of our communities and everyday lives. Soaring in prescription drug prices have been taking a toll on American health consumers, but until now most didn't understand how those prices were set. Many Americans have resorted to purchasing prescriptions online often illegally or overseas. The solutions come with their own risk. An enterprising pair of brothers have created their own solution Matthew and Geoffrey Chaiken founded Blink Health, a free online destination that links patients with prescription sources that can be up to 90% cheaper than what's found on the traditional market.

Male: You go to Blink Health.com you look up the name of your medication, the price you see there is the price you get at over 60,000 pharmacies nationwide, you pay for it online. We provide you with what we call a digital blink pharmacy card, you show that card to the pharmacist and that your medication rings up at zero dollars.

Mark Masselli: Co-founder Geoffrey Chaiken to CBS News recently they negotiated prices directly with drug manufacturers.

Male: We actually have contracts with every single pharmacy in United States. What's important for consumers is that when they go to Blink there's one price that they're going to see, they will get that price no matter which pharmacy they go to.

Mark Masselli: The element that makes it work so well is customers can purchase the drugs online, but still pick them up at their trusted local pharmacy. Since Blink launch year users have saved millions of dollars on prescriptions and a majority of those prescriptions are filled for 10 dollars or less. Blink an online site for purchasing prescription drugs, offering consumers and option to safely fill prescriptions at a far more competitive price than the going rate, allowing them to stay healthy and safe significant money at the same time. Now that's a bright idea.

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Margaret Flinter: This is Conversations on Health Care I'm Margaret Flinter.

Mark Masselli: I'm Mark Masselli, peace and health.

Conversations on Health Care broadcast from WESU at Wesleyan University, streaming live at www.wesufm.org and brought to you by the Community Health Center.