(Music)

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

Margaret Flinter: And I am Margaret Flinter.

Mark Masselli: Well, Margaret, interesting report from the Centre for Medicare and Medicate Services, CMS reported that healthcare spending held at the modest rate of 3.6% growth in 2013. That's the lowest rate of increases since 1960 when CMS kept records on the rate of inflation.

Margaret Flinter: Spending indeed has slowed across a number of areas, private health insurance, medicare, hospitals, physicians and clinical services, and out of pocket spending by consumers, which I think might be the key to all the other ones.

Mark Masselli: And let's start looking at those numbers, and the causes for them including the recession, and changes in spending for things like medicare due to the Affordable Care Act.

Margaret Flinter: As more Americans rely on high deductible insurance plans, one in three American families report that they have put off seeking medical attention due to out of pocket cost and that's got to have an impact on spending as well.

Mark Masselli: Analysts say now that the economy is improving that might send healthcare spending higher in the coming years. Also, the market is shifting so dramatically with millions of Americans now buying health insurance on online markets, and it's not so clear yet how those things will effect healthcare spending moving forward.

Margaret Flinter: Well, we spent $2.9 trillion on healthcare in 2013, that was roughly 18% of the National GDP and at least when we look comparatively at other developed countries that's too big a chunk of the economy.

Mark Masselli: The cost of medical education is also rather high in this country, and the cost of training one physician can run into millions. It's making health policy officials rethink new approaches to fill in the gaps in healthcare workforce using some creative ideas.

Margaret Flinter: Well, that is something that our guest today is quite informed about. Dr. Fitzhugh Mulan is a pediatrician, writer, health policy expert, also an expert on graduate medical education and training in this country, and has some insights into what kinds of changes might be called for, and how best to prepare the healthcare workforce for the future.

Mark Masselli: Lori Robertson, managing editor of FactCheck.org. looks at more false claims spoken about health policy in the public domain. But no matter what no matter what the topic, you can hear all of our shows by going to chcradio.com.

Margaret Flinter: And as always if you have comments, email us at chcradio@chc1.com or find us on Facebook, Twitter at CHC Radio. We would love to hear from you. We will get to our interview with Dr. Fitzhugh Mulan in just a moment.

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

(Music)

Marianne O'Hare: I am Marianne O'Hare with these healthcare headlines. What a difference healthcare law makes, in the past five years the Department of Health and Human Services has become the third largest payer to outside contractors after the Defense Industry dominated this space for decades. Well automatic spending, cuts and a shrinking military presence in Iraq and Afghanistan have led to some sharp declines in defense spending on private contractors. Conversely the Affordable Care Act has lead to increased government spending on health related contractors. Health spending from HHS has increased to a 147% since 2009. Change in the wind of the Office of National Coordinator for Health IT, ONC is emphasizing two directions continued momentum and adoption of EHR technology, and better interface of that data as well. Ninety four percent of eligible hospitals and close to 80% of eligible physicians have received payment for either purchasing or meaningfully using a tested certified EHR. But the program left gaps by not extending payments to behavioral health, long-term care and other providers. The ONC and other federal agencies are looking at ways to help these excluded providers cover the cost of buying electronic health records. Giving birth in America, fewer women are heading down the maternity road. Statistics show a 6-year decline in birthrates in this country. In 2013, there were 3.93 million births down 9% from the high in 2007. The economy is largely to blame. And a recent analysis of the significant decline in teen births has been attributed in part, according to a study, to the reality show '16 and pregnant', which depicts the lives of teen mothers, and the struggles they face daily to stay in school while caring for a child. The study showed a dramatic uptake in Google searches for things like birth control which spiked nationally every time an episode aired. The reality of watching their peers struggle with lots of freedom abandoned by the baby's fathers, and challenges involved with raising a child really sending that message home. I am Marianne O'Hare with these healthcare headlines.

(Music)

Mark Masselli: We are speaking today with Dr. Fitzhugh Mulan of the Murdock Head Professor of Medicine and Health Policy at the Milken Institute School of Public Health at George Washington University. Dr. Mulan is also Professor of Pediatrics at the George Washington School of Medicine. Dr. Mulan served as Assistant US Surgeon General, was the Director of the National Health Service, coined as a member of the Council of Graduate Medical Education, an editor at Health Affairs. He has written numerous articles and books on the subject of healthcare including 'White Quote Clenched First.' Dr. Mullan welcome back to Conversations on Health Care.

Margaret Flinter: Thank you Mark. Glad to be here.

Mark Masselli: Yeah, yeah, it's been four years since you have been on our show, and much has changed in the Healthcare landscape. And, you know, at last count some 10 million uninsured Americans have gained coverage. And we are on track hopefully for millions more in the second round of open enrollment. But much of your career has been focusing on closing the health disparity. So, could you illustrate for our listeners the fundamental importance of giving millions of previously uninsured Americans access to healthcare, and what's the potential impact of that one fundamental change of access in the nation's health policy?

Dr. Fitzhugh Mulan: Well, once upon a time in the year 1900, it probably didn't matter if you had access to healthcare. In fact you may have suffered ill effects in the hands of physicians. As the 20th century progressed, medical science improved. Antibiotics were invented. Diagnostic tools such as x-rays came along, and it did matter whether you had healthcare. And people without money had to rely on charity care of some sort, which was in short supply. By the mid 20th century, we had health insurance that stepped in as a vehicle to allow people, and their employers to put money aside, so that when they got sick, they had access. In 1965, Medicare was enacted, because old people didn't work, and didn't have coverage. The government stepped in, and provided what has become a very popular program. It also provided Medicaid or also an enacted Medicaid at that time, which has been a spotty effort to cover the poor. Every state runs it differently, levels of eligibility vary, and that's where we found ourselves at the beginning of the 21st century with some 40 or 50 million Americans about 15% of the population without access to the healthcare system. And the Affordable Care Act has been a principled effort to get at that. It's a complicated issue to begin with, with the terrible fractiousness in general, and Republicans by and large not subscribing to the notion that there was a public role in trying to assure access for those who weren't covered. It adopted health insurance, which is not a terribly efficient way to provide access, but that was one of the compromises needed to be made. And we have the bill that we have before us, which is a huge step ahead morally, and it's a huge step in terms of beginning to fill in the system. But it has made considerable progress. And we know that there are millions of folks now who are covered who wouldn't be, and more to come. And it's only as more people get on over a period of time that we

will be able to measure the full impact. And in fact I believe in many that the full impact will be greatly appreciated by the population as a whole, and you will have a huge constituency for what will then we look back on, I suppose as Osama Care, and I think it will be as popular as Medicare a few years down the road.

Margaret Flinter: Well Fitz you've -- as often as we talked about bringing millions of people into the ranks of the insured. We also talked about and who will take care of these individuals? And so the whole question of the capacity of the primary care provider, and the health profession workforce generally was huge. And you've commented on this question of, is there a shortfall of primary care providers, and the degree to which our way of training future physicians in particular through Graduate Medical Education might have to be a just of course The Institute of Medicine just released this report, and Graduate Medical Education called for the establishment of a transformation fund, which might look at can we do somethings in a new way? So maybe you could comment on that area for us?

Dr. Fitzhugh Mulan: Surely, Margaret. There are really two questions here. One is the question of adequacy. Do you have a shortage, and where are we headed in terms of numbers of providers? And the second is since -- for medicine for medical practitioners, Graduate Medical Education is the final common pathway into practice. The US Medical School graduates are joined by US Osteopathic School graduates, who are joined by International Medical graduates, and then the International Medical graduates who are non-US citizens. So, all of those candidates for practice come together in GME (Graduate Medical Education), because in order to get a license you need to have Graduate Medical Education. So, how we manage and fund and subsidized Graduate Medical Education is terribly important, which why that report is long overdue and very welcome. So, the first question, shortage. So, there is fair amount of flexibility in the system. And a lot of what happens is local convention. Primary care is the bedrock of a system. That needs to be robust, and all kinds of studies have demonstrated this, in terms of outcomes, in terms of costs, and in terms patient satisfaction. The more robust the primary care situation is in a community, the better the outcomes in general, the lower the cost, and higher the patient satisfaction will be. In practice primary care physicians make roughly half on an average as specialists do. And their work lives are generally less controllable than certain specialties. So, we have a long standing unlevel planning field in this country of primary care, and then what medical students choose. That problem is with us. We are definitely short and (inaudible 11:01) be shorter as we have more people arriving in the system. But if the system as a whole short, and the answer is probably not, more people will be insured under the Affordable Care Act. And as we are an aging population, our demographics are moving to the elderly, who clearly consume more health services, including importantly primary care, which can sort out the problems the elderly more effectively than sending everybody to cartload of specialists. Does that mean we need to put a lot more doctors into the field? My own thought is we need to grow as the population grows. But we

have good evidence that putting doctors in does not necessarily distribute them better, and there's a notion that if you graduate more, they will distribute to areas of the country that are in shortage. We have good evidence they don't distribute well. They tend to well up in the already well served areas. So, if have shortage problems, the first answer is not, there are many people, for example, just put more doctors out and they to tend to stay as many of us would in areas where the living is easier. And that's where there is money. Secondly, as things get tighter, we need other solutions. The doctor solution is an expensive one. Other solutions calling on our creativity whether it is minute clinics at one end or nurse practitioners, and TAs at another, there are many other ways to deal with, and increasing demand. And simply using the model that we have now and I will call it 20th century model, it tends to use a lot of specialists, and that's one of the major reasons we are an out liar in the world in terms of the enormous amount that we pour into our system without terribly good results. In 21st century, we need to think through that, and work through that. And a tightness in the system will lead to creativity. And what you are seeing now particularly with the ACA are enormous burgeoning of other solutions or other approaches ranging from accountable care organizations. A great emphasis on population health, much more emphasis on data use, early intervention, the use of other providers such as nurse practitioner and PAs. So, there are many ways to treat this issue to skin this cat. And the old way which is simply pour more doctors on it, many of us feel will be very expensive, and not very effective. And our job, the job of the (inaudible 13:29) report was to talk about, how you manage this GME system, addressing the new kinds of competencies, and the new kinds of locations, where our doctors need to work, and they proposed a transition plan that is transform of a nature, and really is the first comprehensive alternative to the current plan that has been put forth. And finally and unfortunately, the leadership group in the medical education community is very much wed to the current system, which is quite remunerative to particularly leading large teaching hospitals, and has been reluctant to take seriously this question of transformation.

Mark: We are speaking today with Dr. Fitzhugh Mulan of the Murdock Head Professor of Medicine and Health Policy at the Milken Institute School of Public Health at George Washington University. And he was the Assistant US Surgeon General and served as Director of the National Health Service corp. You know, I think, yours was maybe in Mississippi, you certainly brought you face to face with huge disparities faced by Americans in terms of access to care. And the Affordable Care Act is putting in a number of measures in place at addressing such disparities, and access, as well as, trying to build a more diverse workforce. Can you talk to our listeners about some of those measures in ACA that is impacting the workforce diversity?

Dr. Fitzhugh: The ACA puts a great deal of more money into the National Health Service corp. There are now about 10,000 health professionals in the field in shortage areas, complement to the National Health Service Corp, and that's

good. That's double the size it was previously. But that sun sets at the later part of this year, and it isn't clear that the congress is going to re-up anything near the level of support that currently is there, a huge problem. Secondly, community health centers, federally qualified health centers, the core of the safety net ambulatory system in this country. And again it got a big bump up, and that sun sets, and it's unclear what's happening there. There are modest investments in Medicare payments, increasing primary care pay a bit. And those are the provisions, there is one important one that also sun sets teaching health centers where there are now 60 community-based organizations that have applied for and 1 grant to do residency training. These residence train at local hospitals, but their primary identity, and their primary clinical training sight is a community based organization, and they learning medicine from a non-hospital perspective while working, and getting their clinical skills in a local hospitals. This changes the paradigm a bit. And that's been a very good experiment. So, that ACA has put ideas on the table in terms of developing the workforce, but those are less than we might have, and most of them are at risk as ACA moves forward.

Margaret: I know that your connection to the community health center movement has stayed stronger over the years, and I have had the pleasure of visiting the Upper Cardozo Community Health Center. I know that you work there as a pediatrician for many years. And certainly represent not just access to care about innovation and care in serving a population that is overwhelmingly at lower income members of racial and ethnic minority groups. And this ideas of the community health centers as a locus of innovation in the redesigned of health care is something near and dear to our hearts. So, I wonder if you might want to just take a moment to talk about some of the key innovations that you see either a rising out of health centers of or being adopted by the health centers and then taken to scale.

Dr. Fitzhugh: Well, health centers have long had a mandate. They sit in communities, and by definition, and by law they are community institutions. They require to have community boards, they are required to serve all regardless of ability to pay. So, they are dealing with populations who have a community sense often are disadvantaged in the sense of being poor, and that this notion of community oriented primary care delivery, which has been a kind of hypothesis, they have actually been practicing. In today's policy discussion, this notion of population health of trying to prevent illness from deteriorating is very much at the center of the debate about how do we modernize, and make our system more effective both in preventing illness from a system point of view. And health centers have been out there struggling with that for a long time when nobody was even talking about it. Community based training really has been a very much of a sidebar of our standard system back to this notion of a teaching health center. All doctors are hospitalized in their training. They spend most of their working hours, most of their educational hours in large institution. But most patients are ambulatory most of the time. And we seek help at doctor's office or community clinics, and our training really does not go on there in any appreciable degree.

Deinstitutionalizing training particularly for primary care docs, but for others as well. Surgeons at the operating room is their big tool, but more and more ambulatory surgery is being done to help the push to develop teaching and training, and role modeling in communities is very important. It's very hard to move that -- some of it out into the community. Community health centers, they are really pioneering a new kind of training. But will certainly put new competencies, and new values into the practice of medicine, nursing, dentistry right through the health professions, which are more community oriented population focused, hopefully economic and efficient.

Mark: We have been speaking today with Dr. Fitzhugh Mulan the Murdock Head Professor of Medicine and Health Policy at the Milken Institute School of Public Health at George Washington University. You can learn more about his work by going to publichealth.gwu.edu. Dr. Mulan thank you so much for joining on Conversations on Health Care.

(Music)

Mark: 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 nonpartisan, 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: Well, President Obama's executive actions on immigration include a $3,000.00 bonus to employers for each immigrant they hire, instead of a US citizen, not exactly. But that's what some Republicans and Conservative media outlets are saying, and it has to do with the Affordable Care Acts employer penalties. Under the ACA, employers may be required to pay penalties if their employees are eligible for tax credits to purchase health insurance through the large new market places. But those who gain provisional legal status under the President's Immigration Plan wouldn't be eligible for the tax credits. Does that create an incentive to hire immigrants over citizens? Perhaps, but healthcare experts say it would be in rare circumstances. Employers hiring or firing they have done healthcare credit eligibility would be subject to discrimination provisions in the law. Most firms wouldn't even face the potential ACA penalties, because they are either too small, fewer than 50 full time employees or already offer health insurance as 96% of firms with 50 or more employees do. The White House estimates that less than 0.2% of all firms could face the employer requirements. An employer could incur the $3,000.00 penalty if the firm offers insurance, but doesn't meet minimum coverage standards or is deemed unaffordable for some employees, and an employee gets a market place plan with the help of tax credits. But again immigrants affected by Obama's actions aren't eligible for the tax credits. One health law professor told us that if only a few employees qualify for the tax credits, it could be worth hiring such immigrants. But it would require some manipulation to get the math right to both

incur costs for offering substandard insurance, and still save money on the penalties. And that's my FactCheck for this week. I am 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 would like checked, email us at Chcradio.com, we will have FactCheck.org's Lori Robertson check it out for you here on Conversations on Health Care.

(Music)

Margaret Flinter: Each week, Conversations highlights a bright idea about how to make wellness a part of our communities and everyday lives. It's a known fact that the current generation of American children is more obese than any previous generation. And at the Washington DC Community Health Centre, Unity Health Care, a pediatrician was in a quandary over how to tackle this growing health scourge. He began with a unique solution targeted to a teen patient whose body mass index or BMI had already landed her in the obese category. What he did was write a prescription for getting off the bus one stop earlier on the way to school, which made her walk the equivalent of 1 mile a day. Dr. Robert Zarr of Unity Community Health Centre understood that without motivation to move more kids just might not do it. The patient complied with the prescription, and has moved from the obese down to the overweight category, certainly an improvement. He then decided to expand this program by working with the DC Parks Department, mapping out all the potential walks and play area kids have within the city's parks, mapping 380 of them so far.

Dr. Robert Zarr: How to get there. Parking is parking available, if someone is going to drive bike racks. There is a section on PED's, park safety.

Margaret Flinter: Dr. Zarr writes park prescriptions on a special prescription pad in English and Spanish with the words RX for outdoor activity, and a schedule slot that asks when and where would you play outside this week.

Dr. Robert Zarr: I like to listen and find out what it is my patients like to do and then gauge the parks I prescribe based on their interests, based on their schedule, based on the things they are willing to do.

Margaret Flinter: Ultimately Dr. Zarr says with some 40% of his patient population grappling with overweight or obesity, he wants to make the prescription for outdoor activity adaptable for all of his patients, and adaptable for pediatricians around the country. He has planned to create an App for his park's database where providers and patients alike can use it. And one day he would like to be able to track his patient's activities in the parks. RX for outdoor activity,

partnering, clinicians, park administrators, patients, and the families to move more yielding fitter, healthier young people. 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.

Narrator: Conversations on Health Care, broadcast from the campus of WESU at Wesleyan University, streaming live --