(Music)

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

Margaret Flinter: And I'm Margaret Flinter.

Mark Masselli: Well Margaret, we have entered November already, hard to believe that the holiday season is fast approaching, but I don't want the month to slip by without acknowledging Veterans Day earlier this month. We in Healthcare are so cognizant of the unique sacrifices our nation's 14 million veterans have made, and unfortunately, we often see it played out in the Healthcare Arena.

Margaret Flinter: Millions of veterans from Iraq and Afghanistan have created a significant increase in the need and demand for services, but, you know, Secretary McDonald is working very aggressively to modernize the care delivery system, make it more responsive, and he is also really offering healthcare professionals that are seeking healthcare careers, a chance to be part of the solution in the VA system, which is very promising.

Mark Masselli: The VA has been doing some aggressive recruiting of medical students to work for the VA but really a majority of American Veterans and their families receive their healthcare outside the VA system, and there is growing concern that the general medical community is missing symptoms unique to veterans, in particular, posttraumatic stress disorder, toxic chemical exposures from the battle field. These issues are not only affecting veterans but their families and loved ones as well Margaret.

Margaret Flinter: You know, currently there is no protocol in primary care to ask if a patient or family member has served in a war overseas, although we certainly in primary care are now asking if people are veterans, so making that one question mandatory that might open the door to more targeted clinical assessments in a timely fashion before those underlying issues erupt into major health issues.

Mark Masselli: You know, adapting health systems to meet the large population needs is something our guest today is quite familiar with. Dr. Harpreet Sood is a Senior Fellow to the CEO of The National Health Service of England.

Margaret Flinter: Dr. Sood has worked as a clinician in both countries, so he really has a unique point of view on the strengths and also some of the challenges or perhaps weaknesses of both of the Health Systems.

Mark Masselli: Lori Robertson also stops by; The Managing Editor of Factcheck.org is always on the hunt for misstatements spoken about Health Policy in the Public Domain, but 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 please email us at chcradio@chc1.com or find us on Facebook or Twitter. We love to hear from you, and we'll get to our interview with Dr. Harpreet Sood in just a moment.

Mark Masselli: But 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 findings in a recently released study, The Systolic Blood Pressure Intervention Trial or SPRINT showed patients receiving more aggressive therapies for hypertension were able to greatly reduce their systolic blood pressure rates. Those early results indicated that lowering systolic blood pressure to a rate of 120 rather than the standard target of 140 reduced the relative risk of heart attack, heart failure, and stroke by nearly a third and the risk of death by almost a quarter. The study included more than 9,000 patients who had high blood pressure but no diabetes. The mean blood pressure in the intensive treatment group was about 15 points lower than the standard treatment group yielding those better survival outcomes. Clinicians, who enact the intensive approach face challenges though managing stricter interventions, which require more patient monitoring as well as clinical support.

Medi-Cal California's Medicaid program covers 12 million people in that state, good news for access, but not it seems for outcomes when there is a cancer diagnosis. A study out of University of California Data shows Medi-Cal patients fare far worse than those on private insurance. This study showed patient's fared about the same as those with no insurance; also found that Medi-Cal patients were diagnosed with advanced stage 4 prostate cancer more than 3 times as often as patients with private insurance.

Smart Phones may be ubiquitous appendages among the nation's young adults. Researchers at Duke wanted to see if cheap weight loss apps developed on the phones could help the 35% of the young adult population in this country, who are overweight or obese. In a study, a third were given the App, a third given personal coaching sessions on exercise and weight loss, and a third given pamphlets on achieving healthy diets and weights. The personal coaching group had lost more weight than the other two but that lead vanished at the 1 and 2-year follow-ups. Researchers had hoped this relatively inexpensive intervention will provide a low cost solution for the looming health threat of so many overweight young adults. I'm Marianne O'Hare with these Health Care Headlines.

(Music)

Mark Masselli: We're speaking today with Dr. Harpreet Sood, Senior Fellow to the CEO of the National Health Service of England, where he is involved with transformation of care models. Dr. Sood is an advisor to Partner's Health Innovation at Boston and has served as a Deland Fellow at Brigham and Women's Hospital in Boston. He earned his medical degree at King's College, London and his Masters of Public Health at Harvard School of Public Health. Dr. Sood welcome to Conversations on Health Care.

Dr. Sood: Oh, fantastic.

Mark Masselli: You have a special approach having worked on both sides of the pond and, I think, it's fair to say that the healthcare system of our two countries, there are some similarities in scope and purpose, but also some real significant differences. The National Health Service founded in 1948 on the basic principle that all citizens should be entitled to free access to comprehensive health and conversely here in The United States, we're pretty much on a Fee for Service Model and that has priced out many Americans out of decent care, and I wonder if you can describe for our listeners some of the hallmarks of each system as well as some of the strengths and weaknesses?

Dr. Sood: Right, absolutely, you know starting with the UK, I think, it's important to highlight key strength of the National System here. We have a robust Primary Care System, which, you know, has been around for decades, and you know, you recently saw with Commonwealth Fund report that came out that UK Health System still ranks as one of the leading health systems in the world, and I think, these are kind of, you know, important hallmarks for the strengths of the UK System. Looking at the US, in it's own way has it's own strengths, you know, the fact that it has world class research facilities and innovation going on, the pockets of care that are provided have been excellent; level is great, it's polished perspective. You know, the academic and medical centers you have here the Kaiser's, the Mayo's, the Cleveland Clinics, you know the Massachusetts, UCSF and CareMore. What you touched about, there are also Fee for Service aspect of things; it is quite important because, I think, we are now on that stage where you know, both sides of pond, we are looking at sustainability, you know, both sides of pond, we invested lot of money number of years on acute care, but now the question arises is that sustainable, and I won't call that weakness per se, but it is something that's changing. You know, now we are looking at the facts how do we actually make it more sustainable so that from our prospective, the UK's prospective, you know, when that value to tax payers comes and the value to the public is we are accountable for, what are we doing to develop sustainable strategy, and we are seeing now where, where we are looking, you know, to invest more in the community, more in prevention, and that care out of acute hospitals into the community, and we are also starting to see that in the US now where the whole population health approach that we are seeing, you know, with Bundled Payments from these large health systems and others who are now also trying to invest in communities and primary care because

that's how we see sustainability happening and care being placed into people's homes or in their homes, so we must leverage on those strengths to address some of the weaknesses.

Margaret Flinter: Well Harpreet until the passage of The Affordable Care Act certainly tens and tens of millions of Americans were just functionally left out of this system and reform certainly is changing that reality in the US, but we look at the UK, where access to care is given considering the universal coverage there and the fact that consumers pay no fees at the point of care, but the UK system actually goes a step further than all of this and ensures that access to care is a guaranteed right. I would love for you to comment on the NHS constitution. What Healthcare Rights exactly does it aim to protect or guarantee and how does that expand upon the mission of the NHS?

Dr. Sood: Well, we spend 10 pens in every 1 pound in the UK on Healthcare and ultimately the NHS belongs to the people, so the constitution you talk about, you know, we have the principles and values and just touching upon some of the principles that guide the NHS for example: #1) The fact that NHS provides a comprehensive service available to everyone irrespective of gender, age, race, disability, sexual orientation, or religion. It is based on clinical need and not on the individual's ability to pay. The fact that the NHS aspires to be of the high standards of excellence and of professionalism, the constitution that was built, you know, is something that was going to be reviewed every 10 years. It is an important aspect on how we are able to protect and again the NHS 5 Year Forward View for example is based upon all those principles and values we talk about.

Mark Masselli: You know, Dr. Sood, right now, both countries are struggling with the health reform that's going on in The Affordable Care Act. It is being attacked legally and in England talk a little bit about what's happening in the market place there and also the external challenges that are upon you?

Dr. Sood: Yeah, more than two thirds of our UK public believe that the NHS works well. Cancer survival rate is as high as ever here, operation waiting lists are down. Early deaths from heart disease are down over 40%. We've got 160,000 more nurses, doctors, and other clinicians; 22,000 people more in outpatient appointments, however, demand for care is also rapidly growing. We are also faced with the burden of avoidable influences in England, you know, from unhealthy lifestyles. One in 5 adults still smoke, one third of people still drink too much alcohol, and there are more people overweight and obese, and 70% of the NHS budget is now spent on long-term conditions, but this presents us with new opportunities. We know, we've got new technologies and treatments improving our ability to predict, diagnose, and treat disease, and we have got new ways of delivering care, so, you know, we once dissolve traditional boundaries between how care is delivered, we want to improve the

coordination of the care on patients but also we want to improve outcomes in quality. The NHS published the 5-Year Forward View, which was the first time ever the NHS as a system has come together and published this document, which looks at where is Healthcare going in the next 5 years in England, and it identified 3 key gaps to this. First was the health and wellbeing gap, and what this is saying is that if don't get radical upgrade in prevention, we are not going to be achieving what we are going to achieve, so we are backing National Programs on Prevention, so with the NHS Diabetes Prevention Program, the second gap is the Care and Quality Gap and this will be filled in with the whole new models of care that we talked about, so what we want to have is 3, 4, or 5 may be care models that work and we can replicate and scale across the country. One firstly is the Primary and Acute Care Systems and this is to hold, you know, how a large health system virtually integrate in having potentially Primary Care Practices but also Community Hospitals in a one kind of system approach. Second is how do we scale, you know, primary care, so we are going to form these kind of multi-specialty community providers, looking at how are we at scale providing primary care, with specialty care in the community, and thirdly, the key one is, and how are we providing enhanced care in care homes, who are looking after our elderly care population but then we now have added, looking at acute care and how we formed urgent care centers around that and developing what we call [inaudible 1206] and we have 50 of those in the country, all pushing these care models at scale so that we achieve good replication all across the country. If we don't get more efficient and make more investment, we will have a gap of 30 billion pounds that we have identified by 2020, so you can see where we are headed and the urgency and the need of this transformation that we have to make in order to make the Healthcare System in this country more sustainable.

Margaret Flinter: Well Harpreet, I was listening for what I might ask you to comment on, I think it would be the issue of work force. We hear so much in The United States about part of the negative impact on Primary Care being the incredible debt load that our young Healthcare professionals come out of their training with and that this influences the choice of careers needing to really select a more lucrative career, tell us about how this workforce issue is addressed within the UK in terms about the cost of education or salary differentials. Just shed a little light on that?

Dr. Sood: So, I mean, compared to US for example, medical school here is much cheaper. So, you know, you can pay up to maximum 9000 pounds a year now at medical school. At my time, I paid 1000 pound compared to US where you can pay up to the end and have up to 200-300 thousand dollars debt, so I think that is an important aspect of the work force here. In terms of salaries, I mean, look, there is a range of, you know, what specialties you choose. From a central perspective, we do have a kind of scale up pay for trainees as we move along and then when you get to consultant level,

you have your basic pay rate, well that can be supplemented with bonuses or little bit of private practice, almost like a Primary Care, you know, from a national perspective is well remunerated, but I think, it is the attractiveness, is what gets people excited in order to work with NHS, for example the NHS manages training schemes, which is, you know, one of the most sort after schemes in this country and probably one of the most competitive thing in this is a 2-year scheme that we have here to train the next generation of managers that come through and you see the national initiative at the moment including our current Chief Executive Officer, Simon Stevens, who have come from that scheme and gone on to achieve stable careers, but we do face a challenge like all health systems; training, we are giving them opportunities providing with the latest innovation, thinking, and also it is in an important way of keeping your staff excited, and we have just, you know, launched the first time a national program on Workplace Wellbeing which is same. We will go out there and produce workplace wellness initiatives and programs for our staff in the NHS to not only live healthier lives but, you know, give them that mental health well being and space so that they really thrive on what they are doing and doing it well.

Mark Masselli: We are speaking today with Dr. Harpreet Sood, Senior Fellow to the CEO of the National Health Service of England. Harpreet, you had real great opportunities, you had lot of great opportunities at Harvard. You were really able to dabble in the startup culture and you and your colleagues were examining how technology specifically gaming could improve the landscape for patient management. Tell our listeners about the Mighty Lungs Project?

Dr. Sood: This was a project that was funded by the Harvard Medical School where we go to the C-Grant, go and kick start a project with the local community health center and really trying to solve that problem of pediatric asthma, medication adherence, and how do we actually incentivize those kids to take the inhalers and this was a big problem. 40% to 50% of the children would end up in the emergency room because they weren't taking the medication, and one of the things that I encourage a lot of entrepreneurs is that how do you go about solving real problems to our providers. So this was a real problem that we were trying to solve for them and then ultimately realized actually this was a problem scaled across globally and so our plan was really to firstly develop a video game that would incentivize children to take the inhalers, and then we would encourage to developing a sense, so every time they took the inhaler, we could monitor that, you know, send them reminders and messages and hopefully be well because ultimately we want to make it more a fun process for them, so that they take it. Concept was great, and we developed a storyboard for the videogame, lot of focused groups, but ultimately, I think, the timing wasn't quite right and it failed but a great opportunity to learn about the whole start up experience, the culture working with a great team, and you know, moving on now I think it is important that what this experience really showed

and this is great thing about the American system, (a) the culture, which you talked about, but secondly the ability to take risks and if projects don't work, let us close them early, which is what we did, but I think going back now if we were to do something again like this, we wouldn't set ourselves such a tall order and maybe bit by bit and doing incremental innovation which will ultimately lead to, I think, bigger gains. That experience in Boston, in the UK system, great people, at Brigham and Women's for example, I was quite involved with helping set up the innovation hub there called the iHub, which, you know, does exactly that. It kind of handholds, guides, you know, frontline clinicians and managers to go and innovate, and it takes their ideas into achieve fully fledged start-up projects, and yes, we are starting to see that in UK now, in the NHS for example, you know, great experience to learn with Mighty Lungs and I am helping now to kind of diffuse that learning in the NHS in England.

Margaret Flinter: What we have in common, you know, Tsunami in the increase in patients with type 2 diabetes and particularly what we see coming in through our adolescents and diabetes is both about the basics, diet, exercise, medication, --- Yeah --- but it also requires that we think about innovation, and we think about taking some risk. Can you tell us a little bit about the diabetes prevention program that's being implemented, which you are overseeing?

Dr. Sood: Yeah, type 2 diabetes constitutes for over 90% of all those with diabetes in England, and at present, it is continuing to rise at an alarming rate, and you know, we spend – the human cost – the annual NHS cost of treating diabetes is estimated to be around 10 billion pounds, which is, you know, roughly 10% of our NHS budget, so you could see the scale and the gravity of the situation, yet the diabetes prevention program, you know, this was a kind of randomized control trial. Five major randomized control trials have been conducted, you know, China, Finland, US, Japan and India, and they have documented, 30% to 60% reductions in type 2 diabetes in youngsters and adults who have impaired fasting glucose through intensive lifestyle interventions that you talk about. The biggest out of these was the US based diabetes prevention program and that showed people with impaired glucose tolerance, who lost 5% to 7% of their body weight and achieve 150 minutes of moderate physical activity per week reduced their chance of getting type 2 diabetes by 58% in over 2 to 3 years. Those numbers speak for themselves, and if this was a drug of some sort, you know, and we would already be using this, and it's has taken us nearly 12-13 years in England to realize that this is an important program that we need to push forward. So we are really going for a national kind of program here where we want coverage throughout the whole country and be the first country in the world that has a National NHS Diabetes Prevention Program. We plan to have this program rolled out in the next 5 years and this again goes back to the 5-Year Forward View plan that we have and I just talked about where prevention is, like I said, the key aspect or strategy and this is an example

of how we want to use this moment in the NHS to encourage individuals and communities to really think about their health, and I think, we can demonstrate this and pave the way with this program, that will really pave the way for prevention to be taken more seriously in this country. It could also demonstrate from a financial perspective that it makes sense and with social perspective using our existing infrastructure around primary care; we need a proactive primary care system to achieve this.

Mark Masselli: We have been speaking with Dr. Harpreet Sood, Senior Fellow to the CEO of the National Health Service of England. You can learn more about his work by going to the Web, england.nhs.uk, or follow him on Twitter at hssood. Harpreet thank you so much for joining us on Conversations on Healthcare today.

Dr. Sood: Thank you for the invitation, and it's great talking to you both.

(Music)

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. Lori Robertson is an award winning journalist and managing editor of FactCheck.org a nonpartisan, non-profit consumer advocate for voters that aim to reduce the level of deception in US politics. Lori what have you got for us this week?

Lori Robertson: At the fourth republican presidential debate Texas Senator Ted Cruz repeated the long running myth that Congress is exempt from ObamaCare. Law makers and their staff actually faced additional requirements that other Americans don't. Thanks to a republican amendment. Cruz said that "the congressional exemption from ObamaCare was fundamentally wrong and that the law should apply evenly to every American, but unlike other Americans who get their insurance through their employers, members of congress are now barred from directly doing so. As of 2014, they can no longer get health coverage through the Federal Employees Health Benefits Program as they and other federal employees have done for years. Because of a Republican Amendment added to the law, members are required to get their insurance through the Affordable Care Act insurance market places, but even after the amendment per congress in the ACA market places, the exempt claim lived on. Federal Government had long made premium contributions to pay for part of Federal Employee's Health Insurance including the insurance of members of Congress, and in August 2013, the office of personal management which administers the Federal Employee's Insurance Program said that the Federal Government could continue to make this premium contributions for Congress, even though members were getting insurance through the market places, and 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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Margaret Flinter: Each week Conversations highlights a bright idea about how to make wellness a part of our communities and everyday lives. Healthcare Providers are forever on the lookout for that magic elixir that can cure a host of chronic ills in one step. A large study conducted by several institutions including the University of Michigan and Edge Hill University in the UK looked at the medicinal benefits derived from regular group hikes conducted in nature. Researchers evaluated some 2000 participants in a program called Walking for Health in England which sponsors some 3000 walks per week across the country.

Female: There was investment in these walking groups and training leaders to take people on walks, finding trails that were good for people to do even if they had health problems.

Margaret Flinter: Dr. Sara Warber, Professor of Family Medicine, at the University of Michigan School of Medicine, said the study showed a dramatic improvement in the mental well being of participants.

Dr. Warber: Depression was reduced, perceived stress was reduced, and people had, they experienced more positive feelings or positive emotions.

Margaret Flinter: Dr. Warber says this is the first study that revealed the added benefits of group hikes in nature and significant mitigation of depression.

Dr. Warber: Because we are really interested in whether, if you are more stressed would you get some better benefits from being in nature and in fact that did pan out.

Margaret Flinter: Walk for Health, a simple guided group nature hike program, which incentivizes folks suffering from depression and anxiety to step into the fresh air with others, improving their mood, reducing their depression, increasing their overall health at the same time, now that’s a bright idea.

(Music)

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

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

Female: Conversations on Healthcare broadcast from the campus of WESU at Wesleyan University. Streaming live at WESUFM.org and brought to you by the community health center.