Welcome to Conversations on Health Care with Mark Masselli and Margaret Flinter. Mark is the Founder, President and CEO of Community Health Center, Inc., a provider of primary health care services for the uninsured and underserved in 13 cities and 218 service locations in Connecticut. Margaret is Senior Vice President and Clinical Director of CHC and is a family nurse practitioner by profession. Conversations on Health Care is a weekly look at the people and ideas that are transforming the delivery of health care in America, and this week Mark and Margaret interview Princeton University Professor, Paul Starr about his new book on health care. In the tech report segment, you will learn about research into the use of Twitter of track disease outbreaks. And we begin with this week's bright idea. Here is Margaret Flinter.

(Music)

Margaret Flinter: Each week Conversations highlights a bright idea about how to make wellness a part of our communities and everyday lives. This week's bright idea recognizes the impact that chickens can have.

We work with communities that really want to address the lack of healthy food in their neighborhood. That's definitely one of the bigger impacts but beyond that it's a really fun thing for people to get involved with.

Margaret Flinter: In New York City, where backyard coops are legal, a group called Just Food is bringing egg-laying hens necessary coop building equipment and training to community and school gardens and underserved neighborhoods. Just Food realizes that chickens don't just provide fresh eggs and fertilizer for crops in these gardens but also an educational opportunity for city children and a way to engage the community. Some participants of the program sell the eggs in small community-supported agricultural systems, others give them away to local food pantries and one school garden incorporated a chicken club to teach the kids about proper chicken keeping. Now in its 5th year of operation, Just Food's City Chicken Project has helped create 14 successful chicken coops in New York City neighborhoods. Creating healthy smart communities through a project that helps feed the neighborhood while teaching kids the value of local food production, now that's a bright idea.

(Music)

Mark Masselli: Today, Margaret and I are speaking with Paul Starr, Professor of Sociology and Public Affairs at Princeton University. Professor Starr's new book is called Remedy and Reaction: The Peculiar American Struggle over Health Care Reform published by Yale University Press. Welcome. You won the Pulitzer Prize for your 1984 book, The Social Transformation of American Medicine, a history of how American medical system evolved over the decades and yet today, our health care system is still being shaped and debated. And as

your current book title alludes to, it's a peculiar American struggle over health care reform. In reading your insightful account of the struggle, it reminded me of the character in Greek Mythology, King Sisyphus who was made to roll a huge boulder up a steep hill but before he could reach the top of the hill, the rock would always roll back forcing him to begin again for eternity. But tell us why the American struggle is so peculiar and how did we get where we are and where are we.

Paul Starr: Well, first of all I hope it's not as bad as the situation of Sisyphus.

Margaret Flinter: We are not sure.

Mark Masselli: We are not sure we think it's genetic here but.

Paul Starr: Because Barack Obama did finally bring that rock up to the top of the hill. But what is really striking is United States just stands out in the virulence of its conflicts over health care. This is an issue which has been more or less settled in all the other major democracies. It's not really a central problem of political conflict. And what is especially puzzling to me perhaps because I first became interested in these issues in the 1970s is that things look a lot worse today than they did 40 years ago. So, in the early 1970s, President Nixon was proposing a plan for comprehensive health insurance for all Americans that was really to the left of anything that the democrats have been proposing in recent years. President Nixon favored an employer mandate and a federal government program for everybody else and Ted Kennedy on the other hand favored a federal government program that would be universal, what we now call a single payer program. And at that time, the idea was well there are these different democratic and republican proposals but there is a consensus on universal health insurance and variety of ideas to control costs and sure enough, we would reach agreement on this very soon, but we didn't, and decade by decade the costs have going up, the number of uninsured has increased, and the battles have become ever more rancorous. This was just completely unexpected.

Margaret Flinter: Professor, one of the areas that you delve into speaking of some rancour and try to make sense of is the balance between the role and the obligations of the federal government and that of the states under the Affordable Care Act which as you say splits the operational and the financial responsibility for many of the major provisions of the act. And you make the point that many of the states that are most vehemently opposing the Affordable Care Act would likely stand to benefit the most in terms of an influx of new federal dollars. I think you call it a case of ideology trumping self-interest. Tell us about the splitting of responsibility and what challenges is this posing for the implementation of the Affordable Care Act.

Paul Starr: Sure. Well, we have long been dividing responsibilities for health care finance between the federal and the state governments. Our two major

programs are first of all the Medicare program which is the federal program and the Medicaid program which is a program that divides the share of cost between the federal government and the states. We also have the children self-insurance program, that's another program with some federal money but mainly run by the states. So we have a long tradition of divided responsibility here in the federal system and insurance is much more generally a state regulatory issue rather than a federal regulatory issue. So it did make a certain amount of sense for the legislation to continue this pattern of splitting responsibility between the federal government and the states. But the difficulty that the Obama Administration faces is that many of the state governments especially since the 2010 election are in the hands of republican legislators and governors who are totally opposed to carrying out the bill. So we have a situation where the federal government has at least given the first shot carrying out the bill to the states. If the states don't carry it out, the federal government will as a backup. But many of the states are digging in their heels and progress is very, very slow.

Margaret Flinter: Professor, you have a number of phrases that really stick with you after you have finished the book and one of them for me was that United States over the last century has really ensnared itself in a policy trap and you describe that by saying, I think if I can paraphrase it that, as a country, we made it incredibly complicated and then we also created some almost protected classes or groups of people for whom there wasn't such a big motivation for change namely the elderly who could now look forward to Medicare and people who get their insurance through their private employers. So I guess one of the questions I would have for you is does the Affordable Care Act now create the opportunity to escape that policy trap or are we just learning to live with it and move forward despite it because we didn't change those fundamental conditions?

Paul Starr: Right. So what I am arguing in Remedy and Reaction is that the partial measures that United States adopted in the mid 20th century created a system that first of all tremendously enriched the health care industry, secondly, protected the most vocal and best organized groups in the society, and third, concealed a lot of the cost from the people who ultimately bear it and finally, gave many people moral arguments as to why they deserved the coverage they had and other people did not. And it's that combination that I think has really had devastating political effects, made it very difficult for us to move forward, got us into a situation where we are spending more than 17% of our national income on health care compared to about 9% for other western democracies and we don't have the additional improvements in health that all that additional expenditure should be buying us. So that's the trap. We are spending so much more and yet we seem so stuck, it's so difficult to move ahead. I do think the Affordable Care Act, what the opponents refer to as Obamacare, I do think that is a partial escape from this trap. But the problem that the President faces, the democrats face is that it hasn't brought them the political gain that they thought it would, and as a result they may lose the election, republicans may repeal it, there won't be that

great resistance to repealing it and so in the end we will be back in that same trap, possibly.

Mark Masselli: This is Conversations on Health Care. Today, we are speaking with Paul Starr, author of a new book Remedy and Reaction: The Peculiar American Struggle over Health Care Reform. Professor Starr, a key player in health reform is the business community; can you pull the thread for us and illuminate the influence that business community yielded in health reform debate? I know they were for it and then they were against it and when they were against it and you reference this in your book, the coalition of big businesses wrote a check for $86 million to lobby against President Obama's plans, shades of Harry and Louise ads during the Clinton effort at reform. What's their endgame in the current battle?

Paul Starr: Okay. This is a complicated story. First of all big business, big employers pretty much sat this out; they were not a major factor in the legislation. The business interest in health care were very much involved and democrats tried to strike bargains with the major health care interest groups so that they wouldn't go all out to oppose reform. And they made a deal with the pharmaceutical industry and with the hospital industry that involved getting certain number of concessions from those industries but also not demanding so much from them that they would go into all out opposition. Now the group that you are talking about that funded the ads, those were the big five insurance companies. And the insurance industry, this is the story I tell in the book and I don't think it's really been told elsewhere, insurance industry was really split over this legislation. Their main lobbying group, the America's Health Insurance Plans endorsed general principles of reform in late 2008 and initially took a relatively cooperative stance toward the legislation. So this was very different from 1993 when the Maine Health Insurance lobby at that time was dead set opposed to any kind of reform and did fund those advertisements and various other efforts to stop it. But this time the insurance industry at the beginning was hoping that they could work out a favorable arrangement. In the end, there was never a deal with the insurance industry. Some insurers were willing to go along with legislation, as I said, the big five commercial insurers were against it, they were the ones that wrote the check to sponsor the ads that came very late in the whole process, by then it was too late to stop it so in the end they were not the force that they had been in 1993/94.

Margaret Flinter: Professor, the theme of fairness comes up multiple times in your review of the issues and I think of that as a very American part of the character of Americans. And here are two examples of how the Affordable Care Act tries to balance these concerns about fairness; one, the issue of how we look at how much people should pay based on whether they are young or old, setting insurance rates for the young or old but also, and I was so glad to see you address this, the issue about coverage for immigrants about this concept of balancing fairness and how it played out in those two very different areas.

Paul Starr: Okay. So these are really complicated issues. In the current insurance market, older people are charged a rate that reflects the additional costs that they represent. So a 60 year old applying for insurance individually is going to be charged a great deal more than a 20 year old or a 25 year old. Technically, this is called the issue of age rating, what should be the ratio in the prices charged to older and younger people? If you just let the market charge, let the market what's called an actuarial fair rate one that reflects the actual health care cost, many middle aged people and older people under age 65 will not be able to afford the insurance. And on the other hand, if you compress the rates, if you bring them closer together, you are going to raise the rates for younger people, and some of them won't buy insurance. So there is a tradeoff here and I try in the book to go through these issues carefully and to explain why in the end the legislation sets a ratio of 3:1 from older to younger people in terms of the rates that insurers can charge. Some people on the left think that's too high a difference between old and young but it's a lot smaller than the range of prices in the market today. So this reform compresses the prices, it also provides subsidies to low-wage people. Many of the younger people who would otherwise be charged a higher rate than they would in the market today will actually find they have subsidies in this new reform that enable them to afford coverage at a lower price. So there are lot of things going on at the same time there. Did you also ask about immigrants?

Margaret Flinter: I did.

Paul Starr: You did, okay then let's talk about immigrants. So we have both legal and illegal immigrants. The law does not provide coverage to illegal immigrants that is absolutely clear. But then there is the question of legal immigrants. Well legal immigrants, they are here legally. What kind of coverage should they get? Currently, legal immigrants are not eligible for Medicaid if it's within 5 years of their coming to the United States, they have to have been here at least 5 years. And some of the immigrant advocates are disappointed that the law did not change that provision regarding Medicaid. But it does allow legal immigrants to buy coverage through the new insurance exchanges with the subsidies that will be available. So it adopted a compromise. And then there is one further aspect to the law which is that it provides additional funding for Community Health Centers and the Community Health Centers that exist usually in low income neighborhoods, often in immigrant communities, those Community Health Centers do treat immigrants both legal and illegal and so, in an indirect way, there is some provision for the health care of illegal immigrants. We have some 11 million illegal immigrants in the country; to leave them completely without health care seems to me just a **yelling** disaster. So the legislation really tries to strike a reasonable compromise. I can well understand why many Americans feel it's improper for the government to give a right to coverage to people who are not here legally, that I understand but still, there are these millions of people, millions of children, we just can't abandon them.

Mark Masselli: The Affordable Care Act though has a number of hidden gems contained with the legislation, community transformation grants, grants to small businesses to create healthier workplaces and many more; what items excite you and what should we be paying attention to and why?

Paul Starr: Well I agree with you there are lot of exciting provisions in here. The law has relatively generous public health provisions which did not get lot of attention, there is more coverage for preventive health care, which I think is part of a long term shift in and thinking about health insurance. Originally private health insurance and even Medicare didn't cover preventive care at all and now we see in this legislation a turn toward much greater attention to that side. I think that's a very progressive aspect of the legislation.

Margaret Flinter: Professor, you are on the campus of Princeton University surrounded by bright, young, innovative, and inquisitive people, but when you look around your campus or the country or the world, what do you see in terms of innovation and who should our listeners at Conversations be keeping an eye on?

Paul Starr: Well, there are all sorts of possibilities I think in applying new Information Technology to health care. We desperately need ways to reduce the administrative overhead in the system, to make the best use of the talent that we have and I think there is lot of energy that are going into Health Informatics and it's really a puzzle here. Because if you look at United States compared to other countries we have been a leader in medical technology and we have been a leader in computer technology. Why shouldn't we be a leader in the use of Information Technology in health care? But we haven't been. Actually there are other countries that have made better use of it in their health care systems. So it is just to me an area where there is a vital need for innovation and where we are I think very well positioned to do it.

Mark Masselli: Today, we have been speaking with Paul Starr, author of a new book Remedy and Reaction" The Peculiar American Struggle Over Health Reform which will be available October 25th from Yale University Press. Professor Starr, thank you so much for joining us today.

Paul Starr: Oh thank you.

(Music)

Loren Bonner: We close with the tech report, our weekly look at how people are using technology to improve health and wellness. I am Loren Bonner. Although it's flu season, Twitter followers will see much in the way of a big panic like there was back in 2009 with the threat of H1N1. Phil Polgreen, an associate professor at the University of Iowa's Carver College of Medicine remembers exactly what Twitter followers were saying about the pandemic. He is part of the

computational epidemiology group at UI. His research team used Twitter to track public concerns about H1N1 and follow real time disease activity.

Philip Polgreen: In the early days of the pandemic, there were lots of concerns about travel and so we were interested in how people were tweeting about flu and travel and because all this data is, we sort of think of it like a micro blog is time stamped and geo-located, we can estimate, get an idea of how many people are kind of worried about travel.

Loren Bonner: In April 2009, the group began collecting and storing public tweets related to H1N1. The tweets matched a set of general keywords like flu, swine or Tamiflu. Additional keywords located tweets that mentioned travel and hygiene. Then in October of 2009, when concern about the pandemic peaked, the team expanded their search terms to follow worry about vaccines and sure enough.

Philip Polgreen: We were able to reproduce the epidemic curve, anticipate when the season for the most part would start, peak, and stop.

Loren Bonner: Tweets can provide a rich set of data for health professionals. Twitter users often don't shy away from complaining about their exact ailments and when they developed. Their profiles often list their location and increasingly, other users can pinpoint their whereabouts even more precisely thanks to GPS devices. But Polgreen admits there are limitations; not everyone uses Twitter and streams are increasingly being clogged with spam. Polgreen says if anything, tracking disease outbreaks using Twitter represents the potential for supplemental information.

Philip Polgreen: It won't replace any standard traditional surveillance approaches but it does represent a new stream of information that allows public health to gather information very quickly that would be hard to do using sort of standard traditional methods.

Loren Bonner: Federal agencies that do track disease like the Centers for Disease Control and Prevention like the idea but right now they are more interested in using Twitter to relay public health messages. Polgreen says he will continue trying to understand disease outbreaks using data and technology with new forms of social media constantly being updated, he will have plenty to study.

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That's Loren Bonner with this week's edition of the tech report. If you have questions for Mark Masselli and Margaret Flinter, or would like to subscribe to the Conversations podcast, you can visit them on the web at www.chc1.com. The health forum is part of connecting our communities from Connecticut Public Broadcasting in partnership with area non-profits and production support for

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