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Introduction

Welcome to another Health Advocate Podcast from the Australian Healthcare and Hospitals Association. I'm Krister Partel, Advocacy Director here at the AHHA, and today I'm sitting down with Professor John McDonough from Harvard University's T.H. Chan School of Public Health.

Between 2008 and 2010, John served as a Senior Advisor on National Health Reform for the US Senate on the Committee on Health, Education, Labor and Pensions, where he worked on the development and passage of the Affordable Care Act—or Obamacare as often heard in the media. John also served as a member of the Massachusetts House of Representatives from 1985 to 1997 where he co-chaired the Joint Committee on Health Care.

John is currently in Australia running a series of executive workshops hosted by AHHA's Deeble Institute for Health Policy Research and the Harvard Club of Australia on leading health reform during political change periods.

Welcome to the podcast, John!

Health systems complexity and politics

Krister: so to get started, from your experience why are health systems increasingly complex and politically driven?

John: because health care and medical care are so central and important to everyone; because we as a society accept that we want these systems to grow to be able to better meet all of the diverse needs; because the healthcare sector and related groups around it are relentlessly innovative and coming up with new ideas, new ways, new technologies, treatments, processes; and because there is so much unmet need out there and a continuous desire to try to get at it as much as possible.

People not getting adequality served, there are diseases that we don't yet know how to treat, but the pioneers of innovation keep coming up with new ways, some successful some not; there's just a relentless drive on society to want to improve health and medical care for their own selves, for their families and for everybody around them.

Krister: there is a lot of change in expectations from the public on what they expect from health systems; and a lot of diseases and conditions that are treated differently today from when health systems were first formulated; and I know the Australian system and the American system are different but I think there are lessons Australian health leaders can learn from your experience in the US.

John: and we can learn from you.

Krister: so how are health leaders in Australia or the US to understand or anticipate or respond to these challenges?

John: well a lot of it is context. Look at Australia versus the US and some things just hit you in the face straight away.

You have a form of universal health coverage so that everybody at least has basic coverage; not true in the US where just around 30 million of our three hundred and thirty million people don't have health insurance at all. That creates a very different dynamic throughout the system. We (the US) are absolutely by far and away the most expensive health care system on the planet, particularly over the past forty years. We are just way more expensive than everyone else. You (Australia) are one of the least expensive systems on the planet, among advanced industrialised nations and so that creates a whole other piece.

Your central public health policy, population health measures indicators are for the most part substantially better than ours, you spend about half of what we spend per person, you have better life expectancy, better infant mortality, maternal mortality, fewer deaths from fire arms, a lower smoking rate. So many indicators with spending so much less; you are doing so much better than we are.

A lot of people look at our system as the envy of the world because it's so advanced technologically, but that advanced technology is not leading to better health; which is really the bottom line as in terms of what we want out of the healthcare system.

It's to treat people when they're injured or ill, or more importantly keep people healthy in the first place in order to avoid that, and your system out performs our system; even though you spend so much less on a per person basis. So just that context is a radically different starting point for talking about Australia versus the US.

Krister: I think that context is important, and I think there is always room for improvement in any health system. Especially in the Australian health system, where we should think of context more often and how we fit into it.

John: and there's no perfect system. There's no system where everything is great; and if there is, they've got blinders on because there are always unmet needs, and inefficiencies, and problems, and inequities for different populations, and for people. So it's always worth keeping that in mind; and keeping in mind the relative complexity of the system, where you are and what your starting point is.

Krister: for the Australian system we are doing quite well in various measures, but I think in the measure of equity, especially out of pocket costs, and you've probably heard that over the last few days, that's an issue here in Australia and the Commonwealth Fund has flagged that as an issue for Australia.

John: absolutely. There's growing awareness around the world; it comes under different names, healthcare disparity and treatment and outcomes, healthcare inequities; different ways of looking at essentially the same problem, which gets at most of what keeps people healthy. It is not the medical care available, but how healthy and safe and secure their housing is, their diet, their ability to exercise and their environment, the air around them; all those things that are sometimes referred to as the social determinants of health—are just essential. So, it's important to invest in and improve medical care to cure people when they're injured or ill; it is also at least as important in investing in those systems to keep people healthy in the first place.

Krister: I think one of the challenges with the social determinants, in the Australian experience, is that governments are siloed and a lot of the issues that lead to ill health are not actually controlled by the Health Minister or the Department of Health.

John: absolutely. That's why there's a trend over the past twenty years, that sometimes is referred to as 'health and all policies', where some governments, particularly in the Scandinavian countries, proactively connect health to transportation issues, to housing issues, to all of these other things.

We have some experts at our school back in Boston (Harvard T.H. Chan School of Public Health) who are looking at the issue of healthy buildings and healthy housing. Right now, we have a big focus on green buildings—making buildings environmentally proactive, and efficient as possible, to avoid waste.

One of the things that happen when you have a really tight building, is that it is so sealed up that there's not a lot of ventilation; so you get a lot of people in there working all day and the atmosphere in there changes; because there's not enough recirculation of air and it actually makes people feel less well and lowers their productivity over the course of the day. So, some of our people are expanding the notion from green buildings to health buildings, which incorporates the green elements, but then looks at the human health factors as well; and that's a really exciting growth area now in terms of policy and innovation.

Krister: it's interesting, the unintended consequences that happens all over health.

Value based health care

Krister: so you've run two works shops now. One in Canberra and one in Sydney. One more to go in Melbourne. Have you had any surprises around how the Australian participants have reacted to the workshop contents; or issues that they've brought up that you have discussed; or any memorable moments that you might take back to the US?

John: I think it's all very compelling and it's fascinating and we have been on this pathway now for a good ten years and in a really aggressive way in the US, moving towards what's called value-based care; where we are trying to improve the efficiency, effectiveness, quality of the medical care that's delivered to the American people through a variety of different mechanisms.

Things called accountable care organisations, bundled payment, penalties on hospitals with high readmissions, all of those things; and we've been working on these now for the better part of a decade, in a really aggressive way; and we know that in Australia you folks are several years into that conversation and process; and so it's interesting how quickly folks here (in Australia) are thinking about this and moving ahead and coming up with creative ideas.

So what I try to offer are some of the lessons—not always positive—exciting lessons from the US, because we are probably further down that pathway then a lot of other countries; and so we invite people to learn from us to avoid some of the pitfalls and mistakes we have made on that path.

Krister: it's really good to link internationally to see best practice, but also what to avoid; and as you might know next week AHHA is actually going to launch an Australian Centre for Value-Based Health Care.

John: congratulations, very exciting.

Krister: thank you very much.

Krister: AHHA's policy director, Kylie Woolcock, has just finished a policy brief looking at value-based healthcare internationally, but then setting the scene for what it means for the Australian context; because obviously in the US, with the system that you have being mostly private and market driven, there are lessons to be learnt there that don't exactly fit the Australian mould; but then there's value based healthcare in Europe. They're all very different systems, you can't really take a cookie cutter approach and bring something across.

John: yes, you need to find something that's fit for Australia. Whenever you put in place a new policy, you know what you hope will happen, you know what you hope won't happen, and then you always have to be prepared for the pleasant and unpleasant surprises as you do it; and the side effects that will happen, sometimes that can become of considerable concern as that goes forward.

In the US we are putting penalties on hospitals that have a high very high rate of readmission of elderly patients within 30 days of a hospital discharge; and we've discovered a lot of things we didn't necessarily know; such as that the control on readmissions might actually, for certain classes, increase patient mortality and so I think, if we had known that then, people would've been more cautious in terms of this headline leap into let's create public policy to drive down avoidable preventable readmissions; and its doing that to some extent and there's also surprises.

Krister: continuing on with surprises, you worked on the development passage of the Affordable Care Act—Obamacare as we sometimes like to say. Were there any surprises or unintended consequences, things that weren't anticipated that have resulted, good or bad?

John: I think the good things is that, it was a very heated controversy and process leading to passage of the Affordable Care Act in 2010; and normally after something passes, then both sides put down their swords and shields and try to work on fixing the law; and instead what we have seen in the wake of the passage of the Affordable Care Act is now about 9 years of intense partisan conflict over the implementation of the law; and repeated efforts to try and disassemble it and bring it down in whatever way possible, in a way that is hard to see a parallel in American health policy history.

We created this mass program in 1965, that we call Medicare, that is only for our senior citizens and that was a very difficult, controversial fight; and after it was over both sides then said ok, this is what we've got now, let's work on trying to make it work as well as possible; and it's been the mirror image of that and I think that reflects more than just healthcare policy and politics; it reflects the growing partisan divide in the US that is intense and unending and relentless in terms of how the parties are at each others throats continuously, in a way that really undermines much better policy making generally, not just in the healthcare space.

Krister: political debate that is feisty is always good, but you'd think all side of politics would recognise that a healthy population leads to a healthy economy and more productive and healthy citizens.

John: very different in the US. The difference between US and not just Australia, but every other advanced nation, is that in the US, the notion that every citizen should have access to necessary healthcare as a right is a contested proposition; and that's not true in Australia; and that's not true in any other European or advanced nation that you're going to find around the globe.

It's a sense of whatever the problems are, we've got to make it work; because it's so essential, not just for people's lives, but for a productive healthy workforce that helps everyone, helps the economy, helps it grow. Yet in the US we are still stuck in this place, where we are still fighting about that core essential principle of value.

Because it's not broadly accepted in US society, I think most people agree with it, but the very intense large minority reject it and say, 'No, I'm responsible for myself, and you be responsible for yourself, good day to you and please don't ask me for anything because I ain't going to give it you'.

Krister: cultural differences I guess.

Culture and health

John: culture, by the way, I define culture. I have a definition I love. Culture means the way we do things around here; one of the things that have struck me since I've been in Australia, is that at the start of every meeting; the introduction to the space, the reconciliation.

Krister: the Acknowledgement of Country.

John: the Acknowledgement of Country. That I had not recognised before and I have been taken by it. It's striking; it's been going on for so long, Australians are probably just use to it, and it's probably just the landscape. But coming from the outside it's like wow, this is different; we should have that in the US. We've got our own issues.

Krister: I think it's important when health leaders, or people in the health space come together to acknowledge the country, and I always like to tie it to the gap in health status between First Australians and the rest of the population.

Health leaders need to be cognisant that in everything they do they need to work together to Close the Gap. I know different people draw on different bits, but I do think it's important when health leaders come together to Acknowledge Country.

John: I totally agree.

Sugar tax and health

Krister: If you want health leaders here in Australia to have one key takeaway from your workshop and your time here, what would it be?

John: bottom line. It's the health of the population that counts most. And the health system, the medical system, all the things around it, need to try to serve that higher principle; and that goal as the first order.

So one of the things that stands out in Australia, as a potential weakness is your increase in the rate of obesity; which is going up in the same way as the US. The US is just unbelievable. More than 70% of adults Americans are overweight or obese; and it's actually the obesity part that has been exploding the past twenty years. The overweight is pretty stable, but the folks who are over the obesity level, it's just extraordinary; and so mechanism that can get at that and start to slow down the direction you're going in, or maybe even try and reverse it would be really valuable for the long term benefit for the Australian people… if it's not too arrogant for me to suggest it.

Krister: do you have any experience with the sugar tax?

John: absolutely. My expert colleagues at the school of public health, who are leading analysts and researchers on it; and the examples of Mexico and Philadelphia, other cities around the country and outside of it (the US) now have produced a lot of evidence that it (the sugar tax) is the single most potent effective thing you can do in the short order to turn around the current trajectory.

One of the things that have happened in the US that is really interesting, is that people who have been advancing the public health goal of taxing soda, to try to meet the public health goal, have then been targeting the money that's raised to support and enhance and advance public education; and that has just been a potent combination that has made these referenda, that we call them, weight compelling and passing all over the place. There's also other things that you can do, but nothing that gives you the quick public health punch of substantial soda tax.

Krister: is there any sugar production in the US?

John: oh yes absolutely, Louisiana comes to mind, but others as well in the south.

Krister: and so then, the south would they be more resistant to such a tax?

John: well there's resistance everywhere. It would be especially aggressive down there, where it is more tied to the economy. But it's a controversial matter everywhere it goes, because the soda industry has an enormous amount of resources that they use to politically undermine these advances.

Krister: one last question on the topic a bit more broadly. What about repurposing the ingredients or taking out sugars and sodium and fats from processed foods? I mean it's not always the ideal thing to eat, but there's high sugar and high salt in processed foods. Has there been any work on this in the US?

John: in that sense what's going on; and this was going on very much in the Obama administration, with the First Lady Michelle Obama who was personally involved in pressing food manufacturers to make commitments, on an annual basis, to reducing sugar and salts and other ingredients, on a voluntary job owning exercise; in compelling them to do it, not so much on the public space, in terms of public policy per say.

Our food and drug administration is also trying to prod the food manufactures as well. So, lots of pressure in that way, but not so much the public policy piece. The sharp end of public policy has been the soda tax, because it is understood now, and is recognised to be the most effective shortcut to staunch the increase in obesity and begin to start to move it in another direction. In Philadelphia they saw, even when taking into account people crossing the border into other surrounding communities, a forty percent drop in sale of sugar-sweetened beverages over the implementation of their tax.

Krister: that's incredible; and maybe for our listeners if they're interested in AHHA's position on sugar tax or sugar-sweetened beverages, we have a position statement on our website.

Krister: thank you very much John.

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