Feature Interview

A DISCUSSION WITH PROFESSOR KEVIN IRWIN, TUFTS UNIVERSITY, COMMUNITY HEALTH DEPARTMENT

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TuftScope is pleased to bring you an interview with Professor Kevin Irwin, Lecturer in the Community Health Department of Tufts University. A former Research Associate at the Yale School of Public Health and member of the Methods and Biostatistics Core of the Yale Center for Interdisciplinary Research on AIDS (CIRA), Dr. Irwin is passionate about his teaching and research stemming from a principle of community involvement. In this abridged interview, Dr. Irwin discusses his work with Housing First, a model for serving the homeless population, as well as his opinions on the current health care system and health care reform in the United States. In addition, Dr. Irwin specializes in substance abuse and is involved in initiatives to expand access to Naloxone, which acts as an antidote to opiate overdose. The entire interview will be available on the TuftScope Weblog accessible via www.ase.tufts.edu/tuftscope.

TuftScope (TS): As a new professor in the Community Health Department, could you tell us what led you to come to Tufts?

Kevin Irwin (KI): I was doing full time research for about 8 years at Yale Center for Interdisciplinary Research on AIDS. Most of that research was HIV prevention focused, substance use focused or both. So, I've done substance abuse research in field settings, clinical settings, treatment related research, disease prevention related research. I was also doing training and support of qualitative research methods at the Center in addition to doing research in the US, Russia, and India. I taught some undergraduate courses at colleges in Connecticut, found it very fulfilling, and then decided to transition to a more full time teaching and a little less intensive research life.

I was really looking for the right fit for me. I've always been in an interdisciplinary environment and so it's important that I remain in one. Also in a health oriented environment, so the community health program is a perfect fit for me because we have great students who are absolutely dedicated to the issue of health and they come to it from a multitude of different disciplines. It's really fertile territory for intellectual exploration and a very well established program. I think there are [many] universities scrambling to try and implement some kind of undergraduate public health type of programs, but this one has been here a long time and especially in the last 10 years under Professor Balbach's leadership [the program] has really grown in stature. So it gives me the opportunity to continue my research to some degree, but to teach and explore with students the things that I'm really passionate about. I teach Social Movements and Public Health, which resonates very closely with my interest in community participation. I teach the seminar in Community Health and Drugs, I've taught some version of that course several times. I don't think I've ever had less than 30 students in that course so it's nice to have a seminar version of it here. I'm also really interested in supporting the internship program so I guide one of the internship seminars in the fall session and enjoy working very closely with the students on those field experiences. Next year I'll be offering a full year research seminar. And the other area that's central to my work is homelessness, and I'm doing that right in Somerville.

TS: Can you discuss your work in the Introductory Course on Healthcare in America (CH2)?

KI: Well, CH2 is slightly different for me, it's a policy class. I haven't done the lion's share of my research specifically on healthcare policy. But, I've always done work in and around policy, whether its healthcare policy, public health policy, drug policy, they're all intertwined. It's a great opportunity to explore US health care policy at this point in history especially when it's so dynamic, so many things are happening. Reform is hopefully happening before our eyes. It's been many years since the last serious effort at reform, which never really got off the ground. I think it's clear to most people in this country that we really don't have a choice. There has to be reform. The country that has by the far the most resources, by far spends the most money, yet has very mediocre and very disappointing outcomes on the whole.

TS: What kind of policy change would you support?

KI: We need universal health care. That can come in a lot of different forms and packages. It doesn't appear that a single payer program is going to be forthcoming from what we've seen so far and the [ongoing] health care policy negotiations. Single payer options seem to be off the table, which is disappointing to me. I mean, I think it at least needs to be part of the conversation. It will be interesting to see how we get to universal coverage. But, it's going to be a long bumpy road.

TS: What do you think would work?

KI: Well, depends on what you mean by work. Depends on what outcomes you're looking for. The trick is to effect systematic change that addresses cost, access and quality together. Certainly, we have models that work tremendously well. The VA system[1] works quite well. In the VA system, you have a population that by and large experiences more morbidity than a lot of population segments. Older, mostly men, who are often dealing with multiple chronic conditions, yet tend to still have pretty favorable outcomes. I think that is attributable to the way the system is organized around prevention and the management of their health, as opposed to waiting for them to get sick and treating the acute condition after the fact. The whole orientation to the patient is different in the VA health care system. You visit one of the institutions, you can see it, it's observably different. There are a number of other benefits of organizing so many people in one integrated system. The coordination of care is quite good. There are lessons to be learned here.

TS: What do you think are the primary problems with the health care system now?

KI: We still have this bizarre mix of public and private concerns, and as long as we are going to value market based strategies to provide health care, medicines, or any associated goods, then we're always going to be subject to forces of the market. Does market competition lead to innovation? Yes, but not always in the best interests of peoples' health. I think it is fundamentally a question about our values, and how we value health. It continues to boil down to that. When you look outward to other countries, and not that they all have perfect systems by any means, but those countries that value health as a social good more than an economic or market good tend to have better outcomes for less money.

TS: And the uninsured?

KI: It's obscene that there are 47 million people without health insurance at any given time. The thing is that, the uninsured still eventually get care, but it only drives up costs for everybody. That people have to wait until they're really sick to go get care, that people have to put off purchasing their medications, or taking less of their medications as prescribed, or skipping appointments for necessary management of chronic conditions – [there's something wrong with that]. There's something on the order of 10 to 14 thousand people a day[2], an unbelievable number of people, losing their jobs and many losing their health insurance in the current economic downturn. Care will eventually be given, but usually it's going to be more expensive care, uncompensated care. So those costs have to be shifted somewhere, and they eventually get shifted to higher premiums. So everybody eventually pays, one way or another. Americans really haven't seen the picture clearly – we all eventually pay with our pocketbooks, with our own health, or both.

TS: What do you think are possible ways to cut costs?

KI: Clearly, if you ask people, how many of the 2.1 trillion dollars in healthcare costs go to prevention, most people couldn't tell you. Reorienting the system toward prevention and primary care, as many community health centers do, would certainly help. The raw cost of hospitals, the cost of physicians, and specialized types of delivery are simply more expensive in the US and that doesn't get talked about an awful lot. When you compare the US to other developed countries, you find that people see their physician less often, they spend fewer days in the hospital, and yet in countries with comparable economic profile, our care still costs a lot more. Is there money to be saved in tort reform? Yes, a little bit, that's part of the story. But there are a lot of different places we can cut costs.

TS: What do you think would be one of the more effective ways to cut costs?

KI: As long as we have large entities involved [that] are operating on a for profit basis, as long as they are accountable to their shareholders and not to the people

they are servicing, we're not going to control costs. We also use far too much technology. Some point to the imperative to use expensive technology simply because it is there and generates profits, while some argue that a lot of this use is driven by defensive medicine, in fears of malpractice. Thus, you have advocates for tort reform. But there are people on the other side of that argument who say that the understanding of malpractice that we're presented with is really a myth. That it really doesn't necessarily add up in a way we're led to believe, and that malpractice, or poor practice is the culprit, usually absent any litigation, that leads to additional medical need, time lost from work, and so forth. And it's not necessarily clear how much testing is done from a defensive posture, or how much less could be effective. It's hard to project what the savings of tort reform will actually be.

And so health has been re-positioned, in this very consumer driven society, as increasingly commodified. People are moving toward having things like health savings plans. That's all well and good but that doesn't necessarily translate into universal coverage or shared responsibility. That doesn't translate into health as a social good, that's health as a personal good. My having a health savings account is good for me but not for you. So this movement towards health consumer comes at a cost. It's great for consumers who have resources. As it relates to positioning patients as having a choice about what kinds of services they want to go do and so forth, but we don't purchase health care, especially preventive services, like other goods.

TS: Could you tell us what your current research is about?

KI: I'm currently working on a few things. I'm working on an evaluation of a Housing First demonstration project. Housing First is a model started in NYC by Sam Tsemberis for addressing chronic homelessness. It does away with the model we've always used, which is this continuum of care. This system typically makes people go through certain steps, from being homeless to staying in a shelter, and then if they do fine in a shelter, we put them in tenant housing for 30 days or 90 days, then if they do fine there, we might put them in a halfway house for 6 months. Some people have to go through multiple steps to secure permanent housing. But at each one of those steps we tend to make it rather difficult. Working with a chronically homeless population you're also often dealing with mental health issues and/or substance abuse issues. As it turns out, even if you have access to some sort of mental health or substance abuse assistance, usually it's absolutely inadequate, and secondly it's almost impossible to benefit from those resources when you're living in a church basement with 120 other people. Not surprisingly that's not a very therapeutic environment.

And then in each of those steps in the process, we typically establish barriers, kind of stumbling blocks for people. Folks often don't comply with their mental health treatment regimen or they use drugs or alcohol, which is of course a symptom of their chronic relapsing condition. It's not reasonable to expect people to go from chronically addicted to abstinent, it's impossible. So folks are set up to fail, and they continue to cycle through the system. In many respects the current system keeps folks chronically homeless and doesn't alleviate anything. The fact that hundreds of thousands of people are homeless in the US today, everyday, is obscene. Now in the economic downturn you have all kinds of new people who are homeless, espeicially families. And families when they're homeless often don't get counted as homeless because they are bunking with somebody else or staying at somebody's house or staying at a cheap motel or something like that. The number of homeless children in the country now is awful, you're talking close to 1 in 50[3], it's a pretty horrific number. Rapid re-housing is crucial for this population as well.

So, Housing First asks the question, what does a homeless person need the most? Currently we answer the question by saying, they need drug treatment, they need therapy, they need job training, they need a shower, and so forth. If folks comply with all of these things, then maybe they'll be what we call "housing ready." But if you go back to the question, what does a homeless person need the most? The answer is housing. That's what they need. Lo and behold, if you take somebody and put them in their own permanent housing, a safe and secure environment, you remove the unreasonable expectations and you give them the support they need to stay there, they do an awful lot better. That support is self-directed. Folks gain a stake in their own health, they have a say in how they access drug treatment or mental health services or other kinds of services or employment or an education or whatever it is they want to access. And if they do stop taking their medication for a week, if they do have a drink or relapse or whatever you want to call it, they are not punished with losing their housing. It's understood as a symptom of their condition, just like when somebody is trying to quit smoking,

they may sneak outside and have a cigarette. We don't kick them out of their house, we support their efforts and accept that change is difficult. Folks also experience this tremendous empowerment of having a lease, of having a home, it's incredibly empowering to have a home, especially if that has been absent for a long time.

I've consulted on Housing First projects in RI, in CT, and in NJ and we've seen success rates moving people from chronic homelessness, people that have been homeless years, sometimes 15 to 20 years, no documentation, haven't had a checking account in years, move them into permanent supportive housing and they do quite well. Retention rates of up to 80%, which is better than college students. It makes sense. It also saves a lot of money. Because when people are chronically homeless, they're using the most expensive and acute care services, they're at much greater risk for having an acute condition, for getting injured, if they have psychiatric problems for having, an acute psychiatric event, for people who are addicted, gone to jail, going to the ER, all of these things add up to very high utilization of very expensive services. The ER and prison are expensive services. When you use the ER 30 times a year, that's $45,000 you could be paying for a very nice mortgage. Housing First not only conceptually makes a lot sense, it economically makes a lot of sense, and stands to improve folks quality of life drastically, for which there is no price.

TS: Could you tell us how you became involved in community work and working with underserved populations?

KI: I started out in service delivery doing outreach work, doing drug and alcohol counseling, working in housing, transitional housing. I started out more kind of social work side of things.

I felt frustration and disenchantment with the limits with what we were able to do because of various institutional constraints. It doesn't do any good to give somebody drug treatment for a week and send them back to the same environment. Those kinds of frustrations. So I've always been interested in people's health and I've always had a special affinity for people caught up in drugs. That led me to go to sociology, to try to get a bigger picture, in public health and interdisciplinary settings. I've been fortunate to work with a real diversity of different kinds of folks over the years who do terrific work, and always trying to make whatever research efforts I've been involved in meaningful, and serve the needs of the community and not necessarily my own career first. A lot of these terms roll off the tongue, we're going to do "community-based research." What is that exactly? To go to agencies in the community and ask them what their needs are and what kind of research projects would benefit them, it's something that not nearly enough researchers do.

TS: Thank you for your time Professor Irwin.

References

1. For more information on health care benefits and services from the Veterans Health Administration, visit www.va.gov/health.
2. For more information on this statistic, visit www.americanprogressaction.org/issues/2009/02/health_in_crisis.html.
3. For more information on this statistic, visit www.cnn.com/2009/US/03/10/homeless.children/.

*Hyejo Jun is a Managing Editor of TuftScope. *Interview abridgements were made with the permission of Professor Kevin Irwin.*