1913 Society Luncheon—May 22, 2017

at the Charles Hotel

Panel Discussion: Health Care in 2017 and Beyond

JUDI TAYLOR CANTOR: Good afternoon. My name's Judi Cantor. I'm the director of Planned Giving for the Harvard T.H. Chan School of Public Health and I welcome you. Earlier this year students, faculty and staff of the Harvard Chan School got together to reinforce core values of the school. Please take a look at this brief video.

JTC: Just back from Botswana is our chair of the 1913 Society, Barry R. Bloom, who is the Distinguished Service Professor and a Joan L. and Julius H. Jacobson Professor of Public Health, in the Department of Immunology and Infectious Diseases and the Department of Global Health and Population. Prior to this, he served as chairman of the Department of Microbiology and Immunology at the Albert Einstein College of Medicine, however, after that he was the dean of the School of Public Health for over 10 years. He also served on the National Advisory Board at the Howard Hughes Medical Institute. He's a former consultant to the White House. He has been involved with the World Health Organization for over 40 years. He's currently chair of

the Technical and Research Advisory Committee to the Global Program on Malaria at the World Health Organization. He's chaired the WHO committees on leprosy research and T.B. research, the Scientific Technical Advisory Committee, on the WHO's Special Program for Research and Training in Tropical Diseases. He serves on various boards, has received numerous awards and is an investigator, now, in a Bill and Melinda Gates' Grand Challenge Grant with Professor David Edward, where they have applied nanoparticle technology to deliver needle-free spray drying aerosol vaccines against experimental T.B., with UCLA colleagues. I want you to welcome Barry Bloom. (applause)

BARRY BLOOM: Thank you, Judi. Let me add that you are welcome here and a privilege for me, as always, to be here and see the enthusiasm for so many people in what we do at the School of Public Health.

The film gives you a sense of what we are at the School of Public Health, but not a great sense of some of the things that the school has done and perhaps to just set the stage for current discussions, looking at contributions of the school over time might be of interest.

The single major experiment that made smoking start to disappear in this country was a paper from the School of Public Health. The surgeon general said, "Smoking is bad," and nobody paid attention and when the chairman of Epidemiology wrote a paper on second-hand smoking which said, "If you want to kill yourself with smoking, that's okay. If you want to kill others, that's not acceptable in society," that was the turning point for the diminution in smoking. Later the school was invited to the Motion Picture Association and of the four criteria in making pictures R-rated so kids don't see them, excessive smoking is now one of them.

The school was responsible, Max Essex and his colleagues, for the first diagnostic test for AIDS. The Six Cities Study was the first study, a massive study showing that air pollution actually correlated with increased mortality. We have recent studies showing how the biome affects and causes colon cancer and you all know the nutritional work of Walter Willett and his colleagues, ah, which has led to removal of trans fats from most American foods, although I do think the major contribution, or my favorite contribution, if not the major one of the Department of

Nutrition, is that wine and dark chocolate are really good for reducing (laughter) heart disease.

And finally let me just say there are many other things that I could say but I wanted to say that 90 percent of the gifts in the 1913 program we know go to financial aid for students without which many, particularly international students, wouldn't be able to study at this school, for which we are enormously grateful. That is a major mission of the school and what we do and as I've often said, we've had kids from over a hundred countries and it's a joy to see them whenever I travel, including to Botswana last week.

When I asked the students every year when I was dean at lunches, what was the most rewarding experience during your stay at the School of Public Health, invariably they would say the school was a wonderful experience, but the most rewarding part was the other students. And your contributions to financial aid to students is probably the most important priority I can think of to help the school continue its role in excellence.

And now, we will turn it over to my friend, Tim Johnson.

JTC: Thank you, Barry. I'd like to introduce Tim Johnson, who probably needs no introduction, whatsoever. Tim Johnson is Dr. Tim, as you well know. He is a not only a physician, but he is an alum of the school, 1976. He's one of the nation's leading medical communicators of healthcare information. He's a former chief medical editor for ABC News.

For 35 years, Johnson provided on-air medical analysis on *Good Morning, America, World News, Nightline* and *20/20*. He graduated summa cum laude from Albany Medical College, holds a master's degree in public health from the Harvard T.H. Chan School of Public Health and is a pastor. He has published extensively, received numerous awards and served on the faculty at Harvard Medical School and the staff of Mass General. Most recently, Johnson's been teaching course at the Harvard Chan School on Interaction with the Media and he's here as a co-chair of the 1913 Society, to give us a little state of the union of the 1913 Society. Thank you, Tim. (applause)

Dr. Tim: Back in the, ah, mid 1970s when I started doing this media work I realized very quickly how deficient I was in

biostatistics and epidemiology and so I had an office at the medical school at the time and I ran next door, over a two-year period, and brushed up on those subjects and it's served me very well, so I'm forever grateful to the School for that.

Ah, has been mentioned, I'm vice chair of the 1913 Society and I want to bring you up-to-date. The society has increased with 17 new members this last year, meaning we went from 100 three years ago to 162; we're crawling up. The members have flags on their nametags. If you feel left out, see Judi, she'll sign you up in a minute and we'd be glad to welcome you. There are all kinds of ways to become a member of the society, with appreciated stock, retirement funds, bequest intentions of their trusts and estates and so whether a person gives to lower taxes or get an income for a number of years for the rest of their lives, or lend to Harvard, get to give back, people are finding new ways to join the society and support the School's mission.

I do want to acknowledge the presence today of the vice dean of External Relations, Michael Voligny. Where are you, Michael? Hello, Michael. Been there for 25 years,

doing a great job. (applause) And Anne McClintock, the executive director of Planned Giving for Harvard, I think at the same table; there you are, Anne. Nice to see you. (applause)

We're now going to have lunch and at the end I'll be joined by Barry and Bob Blendon and John McDonough and we'll have a discussion of healthcare in America; whatever that will mean.

Dr. Tim: Thank you very much. We're going to proceed because we are going to stop, as advertised, at 2:00, so you'll eat your desserts quietly and drink your coffee quietly and we'll get this panel started. You've already met Barry and me. Bob Blendon has been at the Harvard School of Health forever and he's world renowned for his work in polling and understanding healthcare. John McDonough I first met when he was in the legislature here in Massachusetts and we've known each other all these years. He's now a professor at the School of Public Health; just a wizard when it comes to healthcare, understanding and policy. So you've got a great panel sitting up here.

We've agreed that each of them is going to speak first for five minutes only. I'm going to keep track and cut him off and then we'll go to some discussion and some questions and answers. So we'll start with Bob and just move down the table, John and Barry.

BB: Hi, Bob Blendon. Can you hear in the back row? You cannot win an election if they can't hear it in the back row. (laughter) Ah, so, I'm going to take the five minutes to give you the story behind the story. Ah, so I want to describe what is actually going on politically.

First is, over 15 years in the United States there has been a polarized separation in views of core Democrats and Republicans on 10 different domestic issues. I know you want to think healthcare is something unique; it's not. The civil war that's actually going on between Washington and the parties is going on in the environment, it's going on in -- income.

Secondly, no one would give a wit, except there's a problem with our political system and the press doesn't like to discuss it because it sounds very anti-democratic. Let me just describe this. So in the 2018 election, based on past

elections, essentially six out of 10 people in every poll will not vote. Absolutely not. Ah, and it may be more; it may be as much as seven in 10 don't vote. So the *New York Times* says Americans, that's my specialty, it has absolutely no relevance for the outcome of the election. The people who actually vote are people very identified with a party, feel very, very strongly about a set of issues and, and come out.

So the parties have paid immense amount of attention to the core of their group. I just want to separate out on health policy very quickly, between Republicans and Democrats. So, you think the federal government should fix the healthcare system? Majority of Democrats, yes. Majority of Republicans, no. Ah, you think the federal government should make sure every American has healthcare coverage? Majority of Democrats, yes. Majority of Republicans, no. You think that Planned Parenthood should be funded by the federal government in the future? The majority of Democrats, yes, the majority of Republicans, no. Let's take a look about the issues on the table. If we fix Obamacare, should the same number of people be covered? Simple

question. Majority of Democrats say yes. Majority of Republicans say no.

How about giving states authority to change Medicaid? Less money, but authority. Oh, awful. Majority of Democrats say yes. Majority of the Republicans say no. How about cutting back benefits and allowing premiums to go down? Majority of Democrats say "Over my dead body," the majority of Republicans say, "Let's do it, with the exception of preexisting condition," that has become the flag. Ah, so.

Put very simply Mr. Trump and Republicans, won in 2016 with three or four issues that their partisans care about. One of them is repealing and replacing ACA. One is a huge tax cut. One is cutting back on immigration. At the moment none of those happened, on the Republican side. So they will be going into 2018 with, what did you do to your enthusiasts? Nothing. As a result, they passed a bill in the House, which everybody knew would be unpopular, in my poll. They actually knew it. And to help them get over that, this would be a sitcom if it wasn't real, Paul Ryan took people downstairs. They played, ah, basically the theme from *Rocky* before they voted and then one of the

members stood up and read select passages from General Patton and then they voted by 217 to 213 for their bill. They knew it would be unpopular. Why did they vote for it?

Because in a partisan election, basically no bill is worse than a bill that is not very popular. So that is what is what's going on and the House debate is going on right now and I'll leave John to deal with all the details. But this is what locked in a room is. Mr. Trump's in trouble over Russia. We are going to be running in a year and a half. Do you want to have three issues where we did nothing? Or do you want to have some compromise bill? And so you can bet on whether or not they'll reach some compromise, though it will not be the most popular.

But remember, the failure of the U.S. political system is that most people answering polls watch it on television. Let me just give you the primaries. In case you don't do that, there will be primaries in 2018. Two out of every 10 people in a poll vote in a primary. The rest of the people, I wouldn't vote for her, I wouldn't vote for him. Doesn't hold my values and beliefs. Turn this channel. They are not participating.

And the people who are participating have very strong, extreme views on this issue and unless we find a way out of that, we will go back and forth. So quickly, I'll close. If the Republicans hold both houses, they will cut back this bill; it will stay. If one house goes Democratic, you will just have a stalemate; nothing will happen. If both houses go Democratic, you will be shocked. "President Trump makes a deal to repair the ACA," says *New York Times*. So the outcome of the election will really matter and the debate is so polarized by who actually will vote and at the moment it looks like Democrats are going to seize the voting booths, but that may not be true a year and a half from now.

But it is this polarization, which has made it impossible to agree on what a healthcare system should look like. It has nothing to do with most average Americans; it has nothing to do with the rationality of healthcare. It is the extreme divisions that have occurred underneath the surface in the United States and we would have this environment if we were talking about schools, if we were talking about inequities; every one of these things, people

are growing further and further apart and that's who's determining the vote.

Dr. Tim: Very good. John?

JOHN MCDONOUGH: Okay. Hi, everybody. Nice to be here with you. Apologies to my friends, who I haven't got around to say hi to yet. I see a lot of you. So let me try to go a little bit, um, higher up, than Bob and just, just a couple of points, because I don't want to say too much because everybody has so much to say and I don't want to hold people up.

But two main points. And this, ah, reinforced in my head by someone from our Global Health Department, Michael Reich, who reminds me all the time; he's done health reform consulting to governments all over the world for like 30 plus years or maybe longer than that and he says, "John," he says, "You know, you have to recognize that the acid test of any health reform, of any nation's health reform agenda comes when there is a transition from a prior administration to a new administration; the president, the prime minister, the minister who put in the reforms and got all the applause and all the attention leaves and new people come in. What do they keep? What do they get rid

of?" Our former dean Julio Frenk was the health minister in Mexico. He put in a universal healthcare coverage plan in Mexico before he came here.

He left as the health minister of Mexico. His reforms stayed. That's the moment of truth. So like it or not, maybe wish that we had a different constellation of leaders who are making this decision, but this is the moment in American society, when we are deciding, of all of these reforms that President Obama got cheers and jeers and whatever, which ones are going to stay and which ones are going to go? And we are learning so much.

We're learning every day a little bit more to help us put this puzzle together. Nobody knows where this is going to end up. We can make some predictions directionally, but no one knows. People thought, for example, at the end of March that repeal of the ACA was dead and it was revived and passed by the House of Representative with two votes to spare on May 4th. So this is a very uncertain environment and so much of what's important is up in the air. We know, for example, that the Medicaid program, which was the little caboose in the law that created Medicare back in

1965 and is now the behemoth that is about half as large as the Medicare program in enrollees, about 75 million Americans, is very much at risk, in the current dialogue.

The House of Representatives bill wants to make radical and severe changes to the Medicaid program and ending its status as a federal entitlement and cutting about $840 billion out of the program over 10 years and a development that just could do nothing except major changes in terms of the durability and reliability of that program.

We know that the Medicare program is absent from most of this conversation and is pretty well safe. We know that employer-sponsored coverage that Paul Ryan wanted to change the tax treatment of in radical ways -- safe. Not going to be touched. And we know that all of the coverage expansion in the ACA around insurance exchanges, a guaranteed issue, banning lifetime and annual benefit limits; all of those pieces are still very much on the table and very much at risk, but we're learning so much as we go along.

And for me, I professionally and just personally have to stay in touch, every day the story is a dancing and

changing in some fundamental ways, sometimes hour-by-hour. It's really hard to keep up with this because there's so much going on. But there's one other big piece, I think, that's worth focusing on and keeping in mind that I think still plays out in this. And that is, one of my favorite political scientists is a woman named **Deborah Stone**, who wrote a wonderful book back in the '80s called *Policy Paradox* and one of the lines that is just branded in my head that I'll never get rid of is she says, you know, much of the policy process represents debates about values, masquerading as debates about numbers and data and facts. And that fundamentally – is true.

So we spend so much time arguing about this study versus that study, these numbers, these polls versus those polls and what do they do? You look at the debates, you turn on C-SPAN, you watch the debates, you see the two parties argue with each other, as if, if I could just figure out the right data point or factoid to throw at the other side, they would throw up their hands and say, oh my God, you're right, I'm wrong. How could I have been so stupid? And that never happens. That never happens, it never happens

because it's not debates about numbers and data. It's debates about values.

And so there is a significant and compelling value that is at stake in this conversation going on right now. When, we travel to other countries and talk to other people in advanced democracies about their healthcare system and I describe the American system, their jaws drop. The things that we do to our fellow citizens in terms of getting access to necessary medical care -- and the fundamental divide in this country is whether or not people believe that access to medical care should be some kind of a human right. Forget about the details in terms of how it's defined. It doesn't have to be single-payer.

Germany, Switzerland, Netherlands have universal coverage and it's almost all private insurance in those countries. But it's the fundamental responsibility of government to make sure that everyone can get the medical care that they need and just, we disagree on that. We disagree on that in the United States. We are so far behind the other countries, in terms of getting over that hurdle. I would suggest that in this process we are making progress and

we're moving further than we certainly were before this whole process and even if we see, over the next several years, some significant retrenchment and step backward, I don't think it will be lasting.

I think that the attitude of the public is changing. I think the public, for example, has an appreciation of the problems with preexisting condition exclusions and medical underwriting and the things that insurance companies did as normal business practice, I think the public appreciates it now so much more than they did on November 7th, the day before the election. There's been this extraordinary public education going on in American society over the past six months around healthcare and what's important and not. The example, the last example I'll give is just, there was a debate in late March about something in the Affordable Care Act called Essential Health Benefits.

The ACA outlined 10 essential health benefits that every insurance policy in the United States has to include, like prescriptions drugs. Like mental health and substance abuse. Like maternity coverage. There was a definite effort in the House to get rid of, repeal the Essential

Health Benefits, in TV shows put up slides that listed the 10 essential health benefits; I'm sure most people were seeing that for the first time in their lives, that this was at stake. They didn't even know it was there; they'd never heard of the term. But they do now.

And so the last thing I'll say, the last is the two quotes that I will carry away from this period forever -- the first one is easy. It was President Trump saying, "Nobody knew how complicated healthcare was," (laughter) right? That will stand out. For a lot of different reasons. But the other quote that I will remember more than any is a quote from the senator from West Virginia named Joe Manchin, who said "Americans have no idea who gave them these benefits, but they sure as hell will know who took it away from them," and so those are the stakes. Very compelling time.

Dr. Tim: Barry is going to give us an example of international health, as it relates to our healthcare system.

Barry Bloom: Let me start with my two, two of my favorite quotes, or relevant quotes. One is from the guy who, a physicist, Leo Szilard, who designed the equations that enabled the atomic bomb to be made and he was asked whether

he was an optimist and his answer was, yes, and a guy asked him, well, what do you mean by, what is the definition of an optimist? "An optimist is someone who believes the future is uncertain." And I think that's -- (laughter) why we have to be optimistic. The second quote is not a favorite --

Dr. Tim: That works.

Barry Bloom: But for someone who's been involved my entire life in global health, America First has certain concerns that it raises. And one of which related to the discussion of my wonderful colleagues, is that a big attack on overseas development assistance, commonly known as "foreign aid" is underway and there's a confounding of foreign aid and global health funded through the government and NIH. And I think that much of foreign aid is military. Much of foreign aid is humanitarian assistance and I would like to argue that that is highly justifiable but foreign aid for health is .07 percent of the entire GDP of the U.S. It's pocket change compared to all the other things we spend money on.

Yet 80-some percent of the public believes we could save a lot of money to the economy by cutting out foreign aid.

What I thought I would do is rather than give you some wonderful numbers on how great things are as a result of research in global health, focus on one thing which is a part of the NIH, a very small part of the NIH called the Fogarty International Center, which is the framework for connecting the researchers and scientists in this country and colleagues abroad and also for training very large numbers of people.

That's been whited out in the president's budget. That will no longer exist, if that legislation is sustained. So I thought I could, rather than numbers, just tell you a story of what training means in the realm of global health. It started 15 or 17 years ago when **Dyann Wirth**, who is the chairman of our department now of Immunology and Infectious Diseases and a world-famous malaria researcher, was in a cab on the way to a meeting in Oxford with a very bright young fellow from Nigeria named Christian Happi and she was taken by this young fellow and she thought he was really quite bright and offered her to come and spend some time as a fellow in her lab, on an NIH grant working on malaria. He did and in fact, he's continued that collaboration after he went back to Nigeria, now for probably 20 years.

It's been very productive. He had done so well with malaria that with the help of the World Bank he was able to get a grant to create a new global health center for molecular approaches to infectious diseases, which the government set up at a new university in Nigeria, right in the heart of the Lassa Fever belt, which he then became an expert on and with another Harvard faculty member now on our faculty as well, Pardis Sabeti, they worked out a diagnostic test for Lassa Fever.

Then in 2014 there were these strange deaths across the border in Sierra Leone. And because Sierra Leone was also a Lassa Fever belt, this laboratory in Nigeria had good relations and collaborations with one in Kenema, which is where the first patients were coming that were suffering from this new unknown disease.

So Christian went out with his Lassa test and showed that these people didn't have Lassa and with a little molecular expertise and collaborations here, developed the first test for detecting Ebola and the first diagnosed case of Ebola in this epidemic came from his test at the hospital in

Kenema in Sierra Leone. Not only did that test work, which was the only test with the current strain vaccine, as opposed to the one the WHO was recommending from 1976.

He went back to Nigeria, was working hard on worrying about Ebola when a visitor from Texas, a Nigerian, came back and collapsed at the airport, was taken to a hospital, unknown condition and Christian himself, four times all night long, ran his Ebola test and identified the first case of Ebola to get into the frontier of Nigeria, a country that has a population of about 150 million people. Think of what would have happened had that case not been detected and Nigeria! He went into action and basically controlled the epidemic with relatively few cases. And finally, his former student identified the first case that flew into Senegal, also with the same test and identified the first case of Ebola in Senegal.

The Fogarty International Center and the NIH has collaborations with scientists in almost every country in the world and is a major supporter of science and research in developing countries, without which they don't have the capacity to deal with their problems and as someone once

said. I would rather be treating Ebola in Sierra Leone than in Dallas, Texas. So these people, the 6,000 scientists trained by the NIH and all those that are funded by research grants to the universities and schools of public health, they are our sentinels. They are who are protecting us and giving us advance warning for all kinds of bad things that are about to happen.

And in the world of infectious disease there are no national borders that are respected. So this is a concern of enormous interest to many people in the outside world, particularly in the developing countries, who are dependent on support, knowledge and training, to be able to create their own functional health systems and we mustn't let that disappear.

Dr. Tim: Great point. And we think about how the NIH in general is under attack now -- money well spent. Warren Buffett, the oracle of Omaha, recently stated and you all saw this probably in the press, that the business community should not be worrying about corporate taxes, they should be worrying about healthcare costs. He pointed out that corporate taxes have actually gone down in the last 50 years, as a percent of GDP, from four percent to about two

percent, but that healthcare costs, as a percent of GDP, have gone from in the last 50 years, from about five percent to well over 17 percent. And if the present inflation rate for healthcare continues unabated, generally about twice the general inflation rate, we could be bankrupt in this country in 10 years. Right or wrong? (

J McDonough: I got into human policy in 1985, when I got elected to the Massachusetts House of Representatives and got appointed to the Healthcare Committee and, um, and I noticed right away in 1985, a whole crowd of people who would come up and tell me, you know, the system is this far away from complete collapse and the sky is about to fall in. And I've heard it, I've heard that prediction every year over the past 32 or 33 years. I don't think we can overestimate the tolerance of society to exist, coexist with a highly inefficient, unworkable, unjust, unethical system because the political challenges of moving in another direction are just too formidable for American society to be able to handle and if you really want to understand the cost of disease in American society, I have to give a book recommendation, is a book by **Elisabeth Rosenthal.**

It's called *An American Sickness*. Came out just about three months ago. Spent about four weeks on the best-seller list. She's a physician who left medical practice to write on healthcare and healthcare costs for the *New York Times*. She now runs the Kaiser News Service. This is an astonishing and thoroughly depressing diagnosis of the cost disease in the American healthcare system and we're all implicated. We're all implicated.

Dr. Tim: So before Bob and Barry jump in, let me add, **George Stephanopoulos** three years ago said to me, um, "In about 10 years we will not be able to sell our bonds on the international market because of healthcare costs and that's when we'll do reform," so, what do you think?

B Blendon: Ah, the problem is when I was a lot younger they had one of the most distinguished economists kick off one of these events and we had honored him and he looked at all of us and he said, "American leaders will never tolerate more than 10 percent of the GNP going to healthcare." No other country had then -- we wrote this down with great authority. He had won all these awards. The National Academy of Sciences had given him, oh, the Brilliance of the Year Award, 10 percent. Okay.

What happen is obviously at some point people have to eat, it won't be all in healthcare, but I think it's quite, and John hit this, to understand a bit about the politics in the United States, the third largest sector on Wall Street, is healthcare. The third largest contributor to U.S. political campaigns is healthcare. One in 10 people in the United States now work for healthcare. You don't know this, the reason why the job picture's gotten better is that basically more healthcare jobs were created since 2007 than any jobs in the industrial sector.

What you discover is there's an incredible dynamic that needs to surface for not having 10 percent of the GNP. If you didn't spend it you didn't know you missed it. Many of you are from Wall Street, I'm not. I've never been at a meeting of Wall Street executives who start out by, "let's talk about no growth as the policy we want to pursue in the United States." So healthcare is likely to grow where -- there is not a political will.

Now at the same time, **Herb Stein** said years ago, something that's always worth having is a non-sustainable trend is not sustained. (laughter) So at some point we will not do

this. But it's a big mistake to not understand how many jobs in Boston have been created in the last seven years in the health sector and why, when **Charlie Baker** went to the Legislature and said, "Let's just have some limits on growth," a Republican governor, they rejected them, with the speaker of the Democratic House saying, "Too many jobs are involved here," so we are in a very difficult political situation. Health has filled the industrial vacuum in the United States.

And it has filled the R&D vacuum in companies and everything else and if we're going to moderate this, we're going to have to live with the fact that there are a lot of people, who in the aggregate get the picture, they don't do very well by slowing their own growth down and that's why politically this has been very, very hard to deal with. But the article in the *Globe* about how women are doing so much better than men in today's economy -- it's because they're entering health jobs. And men don't.

And so this is the other side of "let's contain it to 10 percent." This has not been an easy thing for people in politics to deal with.

Dr. Tim: Barry.

B Bloom: Ah, two points. First is, ah, we know how to give 1950s healthcare. We could do that tomorrow. I'm not sure, given the advances in quality of life and life expectancy, brought every year by new drugs, new, vaccines, and new medical devices which economists at Harvard like, **David Cutler** have felt have been responsible for increases lifespan -- people want that taken away as John said, but nobody wants to take away those things, as well as nobody wants to pay for them.

The second is I spent 10 years as a dean of a school of public health and what we worry about in public health is populations and prevention. And we spend an enormous amount of money in this country on conditions and people for which the interventions, as expensive as they are, are unlikely to add to the quality of life and I urge everyone who hasn't read **Atul Gawande's** book, *Being Mortal*, to realize that something like a third of all healthcare spending is going to be spent on people who will be dead in two years and much of it makes their living conditions much worse.

The third point I would make, I said two, but I'll say three, (laughter) is people forget that there were 24 outbreaks of Ebola in even worse countries, in terms of healthcare systems like the Democratic Republic of the Congo in Central Africa, that were all handled without the U.S. military flying in planes and hospitals, by community engagement, community leaders being told by a small number of experts how to stop an epidemic and block transmission.

That's what the investment in prevention could have done had WHO, in this context, not been asleep at the switch when the emergency calls came in. So investing in prevention, whether it's of infectious disease or obesity and diabetes, training kids, providing better nutrition and the current nutritional guidelines that are being promulgated for the SNAP Nutrition Program, you can buy sodas and you can buy chips, in fact, you can buy diabetes for government money if you choose to do that. We could do a lot better and save a lot more money preventing people from getting sick and suffering enormous consequences when they do.

Dr. Tim: So I have to ask one final question and we'll go to the audience. So if we have all this money flowing, all this

growth, everybody's joyous about it -- why are we the only developed country in the world that hasn't figured out how to use that money for universal coverage?

B Blendon: That's easy. You, and John hit it and it's very hard to say this, as someone who's polled across the world, the values are very different. And the first thing you have to understand is when people talk about the American dream, it's about themselves, their kids, their families. I have polled in these countries and I ask them, do you support universal coverage; it's 70, 80 percent. It's 50-something in the United States, with the parties divided. There's not a sense.

It's not in our Constitution, it's not in any state constitutions and so there are individual values. And then also I'm on the pro-government side, but if you're in polling you know that when Medicare was enacted 65 percent of people said they trusted the federal government. It's now 19 percent. And so, when you go to the country and say, we really want the universal, everybody covered, government's going to pay for it all, you're going to have a battle of people with a great deal of suspicion. So the problem, when we discuss systems is that we believe it's

like an iPhone. I saw it in Geneva and I'm going to bring it home.

It turns out we have a set of values in this country which make it government's responsibility for everybody that's low income, universal coverage harder to get. Not impossible, harder to get and our values are not the same as Canadians. I wrote a piece years ago that said, like it or not, Americans aren't British when it comes to health policy. They really have a suspicion of government-centralized things. So it's a values issue. The minute you have the value, the minute you have a plan. And Americans, and it's very hard -- Harvard, for all of us, is a global institution, I am guilty of interviewing people in Iowa and Kansas. They don't get up and ask what goes on in other countries in the morning.

And they don't compare us to Denmark or this or that. They look at their own lives and everything else. So we have a values problem. It can change over time. We've changed so many different values. But at the moment, our values do not look like western democracies when it comes to universal coverage and the reason why it's important to

know is, you can have a lot of big wins by moving up that, but if you think that we all believe the same thing, you end up failing. Like nobody wants to discuss that in Colorado has a single-payer plan. I've been on five panels. What happened is 80 percent of Colorado voted against single-payer. Even though we in America believe all these things, 80 percent; that's the crowd that voted marijuana in, to get it at the airport. (laughter)

So, these are values that we're going to have to battle out in this country. But as John said, don't forget, it is the values of what you have and want you want for the government and we are not interchangeable with the French. I'm sorry, we're not. I like the food better. Ah, but we're not.

Dr. Tim: Let's take questions. We've got 15 minutes. Ah, I think we've got microphones coming so everybody can hear.

Dr. Thier: Excellent. Problem definition. Solution. What are the next one or two things that you would do, actually do, to get us moving in a direction that is going to improve the present circumstances?

B Blendon: And so we're in a terrible problem and I hope we can work it out. That is, if you woke up in the morning

and the Democrats won every office, we would expand the program we have. We would expand coverage. The problem would be if the cycle ever goes again. We have so politicized this, we have no ability -- Senator Daschle was here and he said he used to have dinner with Republicans in Washington and he can't do that anymore. They, he, people call him on the phone and say, "Don't be there," so, ah, we're going to have the long-term thing; we have to have some ability to have bipartisan agreement and part of this will be settled by election. You'll see, whoever Hillary, Jr. is in 2020 will be for a much larger plan. She will not be for Trump-2, for that.

And so we will have elections, but in the long-term we have to narrow whether it's the environment or others, we have to narrow the gap in this country between influentials on either side of the aisle. Otherwise we will not actually solve these problems.

Dr. Tim: And how do you do that unless you change gerrymandering?

B Blendon: Yes. So there's no question about the low turnout. This is just a quick fact you will remember all the time: Republicans won the House total popular vote by

one percent in 2016. One percent. The one percent got them 55 percent of the seats in the House. That has to do with how the districts are gerrymandered. So the popular vote was by one and the seats are, so the reason why they can vote the way they're voting is the one percent gave them 55 percent. That's gerrymandering.

Dr. Tim: John?

J McDonough: So I would say there are two major parts to the ACA and for the most part the public only focuses on one of them. The part people focus on is the insurance coverage expansions and the taxes to pay for it. There's another big part of the law, which is really attempting to move the healthcare delivery system in a fundamentally different direction. It's in Title 3 of the law in some other places, but all of the various experiments that some of you probably heard of, like Accountable Care organizations, Bundled Payment, penalties on hospitals with high rates of readmissions and hospital-acquired conditions and about 33 other things -- have actually been moving the system in a new direction. It is changing the fundamental financing of the system away from one that is organized and based on fee for service and toward one that is organized in paying by what some people call "fee for value" or other kinds of

things that represent moving away from paying for quantity as opposed to quality and efficiency.

And that transformation is happening in a big way. It is not having the impact or the effect that it should. It is also interesting that while there is big political fighting over the coverage expansions and the taxes to pay for that, there is no political fighting between the parties going on in terms of moving the delivery system in that fundamentally new direction. In fact, in 2015, Republican House, Republican Senate and President Obama all agreed on a law to reorganize position payment in Medicare Part B.

It's a law that's called MACRA. Chances are you never heard of it. But it went through almost unanimously, Democrats, Republicans, House, Senate and president and that is a revolutionary new direction in physician payment. It's got a lot of problems and issues. Question. Does it build on the reforms in the ACA? Does it reject them? Or is it a muddled mass in the middle?

It builds on the reforms in the ACA and advances them. One of the challenges has been for the last seven years, all of

the debate around Obamacare, ACA, has been repeal or not repeal. As opposed to taking what's in there and saying, how can we fix it? How can we adjust? How can we make it work? Because there's no complex law that doesn't require what I call "continuous policy improvement," I'm constantly going back and redoing and fixing and improving and because the parties are so polarized on things around Obamacare, they have not been able to do that fundamental oversight and improvement and that's where I think we have the possibility, because I don't believe there's a big ideological divide, to go further and improve it. I keep hoping we'll get to that stage around the corner, but I can't see it yet.

Dr. Tim: Barry.

B Bloom: I would like to agree with my wonderful colleagues. When our alumna, **Gro Harlem Brundtland**, who was three times prime minister of Norway, was elected to director general at WHO, I got to see her draft speech and in her draft speech the word "solidarity" was mentioned six times. And I called my very good friend in Norway who was one of her advisors and said, "Look, she can't stand up and talk about solidarity. I mean, that is, it's really got bad connotations in my country, we're the biggest, cut it out."

She gave the speech. Solidarity was mentioned six times. Because that was a value.

And I think the question that we, I would like to see all of us contribute to doing something about, is not just how do we change the mechanisms? How do we, how do we get a refocus on values? What does the one percent do with all the money that they have? I have no idea. I've asked the *New York Times* to write a story. I don't know what I would do if I had $40 billion or something like that. I have no idea. I know what Bill Gates has done. I would like to believe I did that. I think the, the question really is at the grass roots level, what are the values? Who is expounding them? Who is articulating them in a way that people can relate to? And the tragedy of the Obama administration, in my view is, no one articulated the values of healthcare, equity for everybody.

Dr. Tim: More questions. Yes, right here. Get a microphone again, real quick. Thank you.

Shaw McDermott: I don't know if you all read the intriguing piece in the *New York Times* in which the author suggested that our system should move towards a Spanish model, which I think they call [Ambruo-terrios?] or something like that; basically a community healthcare-based model was portal of

entry for most problems. Um, I'm wondering whether that has A, functional appeal and B, ah, political appeal?

And the second question, it really is somewhat related to, is another thought piece which suggested that instead of focusing on having Medicare for all, we should really focus on having Medicaid for all, because of its fundamentally decentralized kind of approach, which might better fit with, you know, the American spirit, if you will.

Dr. Tim: All right, who wants Medicaid for all? (laughter)

J McDonough: Well, I, you know, I mean, Spain, Switzerland, Netherlands, Germany, Sweden, England, France, you know, every one of them has features that we would do well to emulate. But it's not really a -- even China and Brazil are countries where we have a lot to learn from them in terms, in terms of changes. It's hard. You have to translate it into an American context.

Dr. Tim: But is it fair to say, John, that all of them, in answer to this question, have strong roles for the federal government?

J McDonough: No.

Dr. Tim: Okay. Which ones don't? And --

J McDonough: Switzerland.

Germany.

Dr. Tim: But they set the rules and they set the prices. Come on.

J McDonough: They set the rules, but --

Dr. Tim: Well, that's a big role.

J McDonough: Well, yeah. I mean, it depends how you define a big -- but there's no public financing in Switzerland.

Dr. Tim: Granted.

M: It is all private, 100 percent private. Anyway. But you know, there's loads of different ways. It's not us versus single-payer. The problem with Medicaid is Medicaid pays so low that if you did Medicaid for all and we can ask Sam Thier here, if he agrees, (laughs) if you did Medicaid at the payment levels, ah, you would turn three-quarters of the American healthcare system bankrupt overnight? Because it pays so little. Then say, okay, well, we'll increase the prices, it's a federal state piece and the governors would go berserk and couldn't raise the money to be able to do it. So it's a nice idea and I think it helps to legitimize Medicaid, but I didn't really see it as a serious solution.

Q: (off-mike) But the cultural thing, you want to deal with it, just a means that the program, not the entitlement programs.

J McDonough: What's an entitlement program for the people who meet that category, just as Medicare is an entitlement program when you get over 65.

Q: (off-mike) Not really. You've got, you have to qualify to get into it. And be something more than 65.

Dr. Tim: Meaning? Ah, what do you have to qualify for beyond the age?

Q: (off-mike) You have your income (inaudible) --

J McDonough: For Medicaid.

Dr. Tim: Oh, okay.

Q: (off-mike) I'm sorry. (laughter)

Q: (off-mike) (inaudible) Medicaid will bankrupt (inaudible).

Dr. Tim: Bob, you want to say something and then we'll squeeze in one more question.

B Blendon: Let's squeeze in one more question.

Dr. Tim: Okay, right here.

Bill Crozier: We hear so much about the, wonderful things go on in our European friends' countries. Can I ask you, Barry, in his travels around, how much those European countries do in the way of caring for their former colonial possessions?

Dr. Tim: Interesting question.

B Bloom: The answer is, we did not formally, except for the Philippines and Puerto Rico, have colonies in the same sense, and yet we are the largest donors, lowest percentage of any industrialized country in ODA or foreign assistance. We still give, by far, the largest amount of money, for countries that were not our colonies, far more than the European countries that give to their former colonies, although French Africa is very much the turf of overseas development assistance by the cyber security of France. I don't see that there's a lot of demand for re-colonization or remaining in that tradition, in the countries that I visit.

What they're really looking for is, what do I need to be self-sufficient? How many doctors? How many nurses? How many drugs? Of what kind? Will it mean that I don't have to depend --

Bill Crozier: (off-mike) What does it mean the, what does France, what do they give in the way of support, the things that we give, in the way of public health?

Dr. Tim: To their former colonies?

B Bloom: Ah, they give lots.

The Scandinavians that didn't have colonies give the most, in terms of healthcare foreign assistance, by far greater as a percentage of their GDPs than the United States. UK? Much better than us. Every one of the OCD countries, we are not in the top 10 in foreign assistance for health.

J McDonough: Also this is a biggie -- in those countries immigrants are eligible for their national health system. In the United States that is not true. So if you were an immigrant in Britain, from wherever it is, you'd get care out of the National Health Service. If I am an immigrant in Germany, I get care out of the National Health System. So I don't, so in Africa, but a striking fact is, when you go to other countries there's not, they came off from some boat, they will not be admitted to any hospital. So, this is a --

Dr. Tim: That would be a value, wouldn't it?

J McDonough: Yes, it is. And it's a U.S. value, which is central to some of the arguments that have been going on in Washington now.

Dr. Tim: We are out of time. This could go on till suppertime, I'm sure. Ah, but let's thank our panel. (applause)

JTC: Thank you, Mr. Moderator.

END AUDIO