[**Music**]

Female: Welcome to Conversations on Health Care with Mark Masselli and Margaret Flinter, a show where we speak to the top thought leaders in health innovation, health policy, care delivery, and the great minds who are shaping the healthcare of the future.

This week Mark and Margaret speak with Dr. Zeke Emanuel, Vice Provost for Global Initiatives and Chair of the Department of the Medical Ethics at the University of Pennsylvania. A former advisor to the Office of Management Budget, he advised the Obama Administration on health reforms. He talks about his latest book, Which Country Has the World's Best Health Care?, and how America is failing at containing the pandemic.

Lori Robertson also checks in, the Managing Editor of FactCheck.org looks at misstatements spoken about health policy in the public domain, separating the fake from the facts. We end with a bright idea that's improving health and well being in everyday lives. If you have comments, please e-mail us at chcradio@chc1.com or find us on Facebook, Twitter, or wherever you listen to podcasts. You can also hear us by asking Alexa to play the program Conversations on Health Care. Now stay tuned for our interview with Dr. Zeke Emanuel here on Conversations on Health Care.

[**Music**]

Mark Masselli: We're speaking today with Dr. Zeke Emanuel, Vice Provost for Global Initiatives and Chair of the Department of Medical Ethics at the University of Pennsylvania. An oncologist and bioethicist Dr. Emanuel is the founder of the Institute for Bioethics at the National Institutes of Health. He served for two years as an advisor to the White House Office of Management and Budget in the Obama Administration.

Margaret Flinter: A prolific writer, Dr. Emanuel has published over 300 peer reviewed articles and 14 books, including his latest, Which Country Has the World's Best Health Care?, and previously with this great title, Reinventing American Health Care, how the Affordable Care Act will improve our terribly complex blatantly unjust outrageously expensive grossly inefficient error prone system. Dr. Emanuel, welcome back to Conversations on Health Care.

Dr. Zeke Emanuel: It's wonderful to be here, thank you for having me.

Mark Masselli: Well, it's great to see you. You joined us last in 2013, which was a time of hope and transformation. I kind of think anytime prior to this was a time of hope and transformation, but it was in the midst of the health reform movement, which was fully underway. Now we are seven years later and we're in the world pandemic and it's really raging across a very divided America. Our death tolls are rising. We

have a national government that really seems unwilling to adequately address the pandemic. I'm wondering if you could share with our listeners, what your diagnosis of the problem we face is, and what's your prescription to get our country back to a safer space till we get to a vaccine.

Dr. Zeke Emanuel: It's really leadership. We have not had the leadership that we should in Washington. We needed leadership that would look at every component along the way, adequate PPE, adequate hospital beds, adequate ventilators, creating a vaccine, supply chains for testing, creating a army of contact tracers. Right now we need to be getting ready for actually deploying that is distributing and administering vaccines, no preparation done. We have had a lack of firm leadership. The President has been obsessed by the economy, the stock index, the Dow Jones, but those are not going to respond well unless we actually have a response to COVID. I mean, people tell you in polling over and over again and also by their behavior, yes they're cooped up, yes the monotony is killing them. But they also are not going to fully engage in economic activity, sending their kids to school, going back to the office, unless they feel safe. Right now it’s hard to feel safe in almost every state in the country.

Margaret Flinter: Well Dr. Emanuel, we are concerned on so many fronts, and certainly one of them has been the administration's seeming attempts to discredit the nation's most highly regarded infectious disease experts like Dr. Fauci who I know you've had a long relationship with. But more recently a really alarming thing is the White House shutting down the CDC’s COVID-19 data collection infrastructure and funneling this critically important public health data, kind of a way from how it had been done into a new and somewhat on the side way of doing it. Can you comment on that for us?

Dr. Zeke Emanuel: Yeah, I think they're trying to hide data they don't like, and I think it's terrible, you cannot respond to a crisis without information. They are trying to prevent people from getting good looks at how the pandemic is unfolding, who it's affecting, how many people are being hospitalized because of it, how much the hospitals are handling, how many people are actually dying, their race, their socioeconomic status, it is appalling. It is so brazen that it's just unbelievable. It's certainly unethical and it's also bad for actually responding for the country. What I really worry about is say, that President Trump loses and you have a new administration, reconstituting all this infrastructure that's necessary to respond effectively is going to be very hard. It will take lots and lots of focus.

Mark Masselli: Well, let me pull a thread on that a little because there's really no shortage of good information and how best to mitigate the spread of the virus. But the information seems to be undermined at every turn

of the corner. In Georgia, for instance, the governor is actually suing municipalities that have issued universal mask orders for people congregating in public. The misinformation campaign has added really a lot of confusion across much of the country on the best protocols to follow. Thanks to you and your colleagues, you've created an easy to read guide. I printed it out for my family this weekend showing the risk factors for engaging in certain behaviors. I'm wondering if you could tell me more about the COVID-19 risk index that you and your team have produced, didn't see going to schools on that list, and your thoughts on that as well.

Dr. Zeke Emanuel: First of all, on going to school we have another risk index that we're going to bring out that's really school specific for exactly that reason. It was just too complicated, and there are too many variables about what schools need to adopt, but we're very responsive. We want to get kids back in school, but that has to be done safely so we delineate the safety. Literally, the graphic designer is putting it into an infographic now. Partially, I just kept getting calls, should I fly on a plane? What if I drive? Can we go to a restaurant? Getting all these questions, so we thought that it would be wise to create a risk index, looking at various risk factors and put it on a scale from safe to very high risk, and it's a five point scale.

There's not data on each decision we make, but we've used a number of criteria, four in particular. Does it occur in an enclosed space? Does it involve crowds of people that you can't really physically distance from? Does it have prolonged time? Are you there for an extended period of time, because we know that increases transmission? Does it involve forced exhalations, that is, sneezing, coughing, yelling or singing that is likely to put a lot of virus into the air and therefore increase your risk of contracting it? On the basis of those four things we look at dining indoor restaurant, compared to playing golf outdoors on an open course. Yes, golf is going to be much safer than dining in an indoor restaurant. Working in an office is going to be less safe than walking out on a trail or playing tennis. That's the kind of metrics we use.

We're against singing in a choir, bad idea, because people are constantly exhaling from deep inside, it's over a prolonged period of time. It's already been translated into Hindi, into Spanish, into French, into Portuguese because I think the world literally, not just the United States, the world is looking for this very clear information about how risky different activities are.

Mark Masselli: I should know my wife's choir's group is doing it by Zoom.

Dr. Zeke Emanuel: There you go. That's very important. We recommend that.

Margaret Flinter: It's a strange world when singing is a risk factor. Dr. Emanuel, you call

yourself an optimistic person but also a realist, and you recently wrote that your best guess for when we return to normal allowing for such things as improved treatments universal mask wearing and a vaccine is November 2021, I'm going to repeat that, not November 2020, but November 2021. We could reach a quarter of a million Americans dead from COVID-19 before the end of this year. How did you get at that assessment and what's going to need to happen to get us to what could even be considered something approaching normal life again?

Dr. Zeke Emanuel: Well, various parts of normal life are going to come back on line at various points. If you say really getting to normal, it's going to require a vaccine that, call it 70% of people have and it's effective. If you just say, all right, December/January is the earliest we're going to get a vaccine that really people respond to. Then as I mentioned, you have to deploy it, you have to manufacture, you have to put it in vile vial, so you have to get it out to where you can administer. You have to put it in people's arms. A lot of people are suspecting we're going to need two doses so you put it in their arms one day and then the next day and then they're going to have to build up antibodies. Just play it out.

The first people who get it are health care workers, grocery workers, first responders like police, etc, then you're going to get high risk people. Then you get out to us, average everyday people who aren't necessarily first responders, that's really going to -- you're talking about the fall or the end of the year. That's how I came to November 21. Could it be January 2022? Okay, but it's in that range. It's not as you say before the end of 2020, and it's not even spring 2021 because we're just not going to have the capacity. We're talking about immunizing 250 million people twice. Just think of the logistics of that. You've got to give it to people. You've got to track people. You've got to figure out who's having an adverse reaction. That's a massive effort.

Mark Masselli: We're speaking today with Dr. Zeke Emanuel, Vice Provost for Global Initiatives, and the Chair of the Department of the Medical Ethics at the University of Pennsylvania. He served as an adviser to the Obama Administration on crafting the Affordable Care Act. He's also an author of hundreds of papers and 14 books, including his latest, Which Country Has the World's Best Health Care? Dr. Emanuel, I really want to talk a little bit about the pillars of this global pandemic story. America is the only industrialized nation in the world lacking some form of universal health care. COVID-19 has clearly laid bare the gaping holes in our health care system.

In your latest book, you examine countries that have far more efficient and effective and sometimes elegant health systems

compared to the US. I wonder if you could share with our listeners what makes them work, how have those health systems contributed to their own COVID-19 outcomes, and what might we learn from them.

Dr. Zeke Emanuel: I have to say, the response in this phase, which is really the acute phase still of COVID-19 is mostly about public health. It's about getting people to physically distance, to wear masks, to do hand hygiene. It's really not about the health care system. When they get sick, yes they're in the health care system and that's different. But the adequacy of our response has not been about the health care system largely, it's been mostly about public health. I think as you point out, it shown some of the great disparities and inefficiencies in the way we're organized, especially about collecting data and the coordination that the CDC can do.

Having said that, I think the standout country probably is Taiwan, they were close to China, they have a million people working in China, and yet they've had fewer than 500 cases and seven deaths in the whole country. How do they do it? Well, the first thing is they were suspicious of China because of SARS back in 2003/2004. That led them to really prepare and to stock pile things like PPE. The second thing is they have a mask wearing culture, so unlike us, they don't have to push people to wear mask. People do wear masks because they think it will protect them from illnesses like COVID. The third thing is they have this health card. Everybody in the country has a health card when they go to the doctor, the card is swiped. The Ministry of Health knows why they're going to the doctor. Then they pay the doctor. They know what the doctor has done for them. It allowed them to rapidly identify people who had been to China so that those people could be tested for COVID and isolated. It also allowed them to identify people who had respiratory symptoms, cough, shortness of breath, other problems that would suggest if they might be at high risk for getting COVID, and they also could be tested for COVID. This allowed them to very rapidly identify at risk people, and test them and isolate them. That's been a big plus.

Germany, if you look at Germany, Germany has a lot of beds and a lot of ICUs compared to all others countries. They have got on a per person basis 40% more beds than the United States. They were able to cope with the very big deluge. In German, also unlike the United States, they're more reluctant to intubate people than we are. We did a lot of intubation and it turns out for COVID intubation is not a good idea. They probably had a lower mortality rate because they didn't intubate people and they had ICUs that allowed them to give patients more attention.

There are many other things in Germany that worked well. The

government jumped on it quickly, listened to the epidemiologist, so you have a much more coordinated response right from the prime minister, who was a no nonsense, really believes in expertise and really believes in execution, unlike our president. As you know, Angela Merkel and Donald Trump don't get along and the different styles speak volumes. They've done way better than we have.

Margaret Flinter: Dr. Emanuel, you're amongst so many things also a medical ethicist and a teacher training the next generation of clinicians, and wow, what a front row seat once in a lifetime seat that you wouldn't want to have for our next generation to have. Looking at this pandemic, they've seen people die in hallways while waiting to be seen in the emergency room. They've seen ICUs that are overcrowded, while other hospitals have capacity. They see professional athletes getting daily COVID testing while some just regular Joe Schmo might not be able to get a test at all. Of course there's the worry about when the vaccine comes out will it be available to everybody easily and with equity. A maelstrom of ethical challenges, I'm sure it's influencing some of your views on ethics and equity in America right now, but also how is it seeing it through the eyes of this young next generation coming up? What are they seeing and how do you think they're being shaped by this for the future?

Dr. Zeke Emanuel: Well, I actually, very, very early on in, I think, March I noted that this was very different than my experience growing up during the early HIV days. In the early HIV days there was this huge debate, should we treat HIV patients? Should we put ourselves at risk for treating the HIV patients? We had none of that debate with this generation. This generation it was quite clear we have an obligation to treat patients, we're going to treat patients. Yes, we're taking on some risk, but that is the price we pay for being doctors. I just applauded them and thought how admirable. I do think this, first of all, this obligation, the sense of duty, very prevalent, we often -- the generations behind us get criticizes, they're so off they are not serious. Quite the contrary, I think that their -- as you pointed out, their seriousness, their commitment, their sense of duty, really admirable, and we should be taking lessons from that.

Second, I would say that, you know, the disparities that they're seeing are something I think that is going to shape them. I would not be surprised if this was a generation very much committed to issues of justice and getting it right. I think that getting rid of the disparities, that minorities or poor people get less good care that they can't come into the hospital as frequently, that facilities aren't located near them. I would think that they're going to be very committed to erasing those disparities. It does seem to offend them very deeply.

I am worried about the gap between here and the fall when we're

going to have another uptick in the colder parts of the country. I worry about burnout, and I think that's something else that this generation is going to have to deal with the sort of intensity of the treatments and the issues. But, I think there's a lot to admire about this generation. I would also say that I've written literally just before COVID came out in January, I wrote an article about moving a lot of medical education online especially the preclinical years where you're learning anatomy and pathology. I got a lot of pushback. Literally as if COVID came to just validate my [overlap] because now Harvard Medical School, the first semester at least is totally online for next year. I do think we're going to learn that. We've got to rearrange medical school, the first pre-clinical stuff we can do that online. The clinical stuff we're going to have to fix how we're doing it. I think that there's in our near term future there's going to be a big shift in how we do clinical education and what really a medical school is.

Mark Masselli: Well, there's a sliver of good news in this terrible pandemic. I want to go back to those early days of the Affordable Care Act. I think we heard from experts and they told us that any big legislation like this is an iterative process. When we pass Medicaid and Medicare, we knew it require legislative changes, and there were dozens and dozens of changes made over the year in a bipartisan way. The same held true for the ACA, but we could never get there because the ACA was demonized.

It now seems like, and this may be too optimistic, there is some support across party lines or at least in the public now, to see continued reforms. As you've noted in your book, we have a uniquely American challenge in fixing our health care system here. What do you believe the next phase of health care reform will look like post-election, post-pandemic, and I think it's fair to say the types of reforms might be dramatically different than the pre-COVID environment with the embrace of telehealth, as you said, online learning a whole different way and other changes that have been done by, unfortunately right now only executive order.

Dr. Zeke Emanuel: Now I think you're 100% right. First of all we've now seen increase in the number of uninsured 5.4 million in the last month, I think. We're also seeing a lot of people lose their employer sponsored insurance because they've been laid off. They're now going to be on Medicaid in the exchanges, and then the anticipation is that literally tens of millions of people who had employer sponsored insurance are going to be on Medicaid. You've got a very different situation going forward. I believe there is going to be big appetite to really reform the system. I just hope that the next president meets that national appetite for reforming the system.

One of the things my brother and I put out there is we do not see how

in the current system you can get a universal coverage given the intransigence of 14 states like Texas, like Florida, like North Carolina, or like Georgia, so you're going to have to take Medicaid and make it a national program. Then I've suggested that we can simplify everything by merging the exchanges Medicaid and Medicare Advantage into one program, because I think Medicare Advantage has been a hugely successful program bipartisan, the seniors who are enrolled love it. I think we can, it's already a kind of exchange. I think we can simplify the system. You have employer sponsored insurance, you're over 65 you have Medicare, and if not you're in this Medicare Advantage exchange program, whether you're poor or not. You can get the universal coverage. You don't have insurance, reenroll you directly in that. That simplification would also save a lot of money on administrative costs. I think that there's things like that.

We also are just going to have to get our arms around the drug spending. It's a huge portion of our bill. We're looking at Haemophilia drug, gene treatment that is about to be commercialized, it's in the approval process, $3 million per patient we're talking about, and we don't even know if it's lifetime. That just seems to me unconscionable and not something we can sustain for a long term. We're the only country that gives drug companies a monopoly and then lets them set their price. Every other country, I'm talking about Switzerland, I'm talking about Taiwan, I'm talking about lots of places committed to the free market, they regulate drug prices, because you can't give someone a monopoly and expect them to price their commodity responsibly. I think we're going to have to look at that as well.

Margaret Flinter: We've been speaking today with Dr. Zeke Emanuel, Vice Provost for Global Initiatives and Chair of the Department of Medical Ethics at the University of Pennsylvania, and the author of the just published book, Which Country Has the World's Best Health Care? You can learn more about his important work by going to www.ezekielemanuel.com or follow him on twitter @ZekeEmanuel. Dr. Emanuel, we want to thank you so much for your enormous contributions to advancing and improving health care for all, for your dedication to public health and the society, and for joining us again on Conversations on Health Care.

Dr. Zeke Emanuel: Thank you very much. It's been a pleasure and a great interview.

[**Music**]

Mark Masselli: At Conversations on Health Care we want our audience to be truly in the know when it comes to the facts about health care reform and policy. Lori Robertson is an award winning journalist and Managing Editor of FactCheck.org, a nonpartisan, nonprofit consumer advocate for voters that aim to reduce the level of deception in US politics. Lori, what have you got for us this week?

Lori Robertson: During a July 14 press conference from the White House, President Donald Trump made the outdated claim that US deaths from COVID-19 are down tenfold. Data from three different sources show that, as of July 14th the total number and seven day average of daily deaths from the disease caused by the coronavirus had declined between threefold and fourfold from its peak more than two months ago. Trump made the claim as he argued that news organizations have recently highlighted record increases in cases of the disease in several states, rather than focusing on the fact that deaths from COVID-19 have declined from their previous high.

At one point Trump's claim about a tenfold decrease was correct. The White House Press Secretary had used the same language in a July 6th press briefing saying that deaths at the height of the coronavirus outbreak were at 2500 per day, but on July 4th there were 254 deaths. We found slightly different numbers. The data aggregation website Worldometer reports that there were 2748 Coronavirus related deaths on April 21 at the peak and 265 deaths on July 4, that's also a tenfold decrease. However, daily deaths have increased in the days since, including in Arizona, California, Florida, South Carolina, and Texas, meaning Trump's tenfold talking point is stale.

On July 14, the day of Trump's press conference, there were 935 deaths according to Worldometer. That's only a three fold decrease from the peak in April. Slightly different totals from two other sources, the COVID Tracking Project and the New York Times also show less of decline in daily deaths than Trump claimed. There also hasn't been a tenfold decline in the seven day average of deaths, which accounts for a fluctuation in daily totals over a full week. All three of those data sources show a decline of less than fourfold from the peak to July 14 in the seven-day average.

Trump does have a point that daily deaths from COVID-19 are "way down" from their previous highs as Trump noted in a July 9 interview, but on July 14, it also was no longer the case that deaths had been cut tenfold as he said. He has simply ignored the increases in daily deaths that have occurred since July 4th. That's my fat check for this week. I'm Lori Robertson, Managing Editor of FactCheck.org.

Margaret Flinter: FactCheck.org is committed to factual accuracy from the country's major political players and is a project of the Annenberg Public Policy Center at the University of Pennsylvania. If you have a fact that you'd like checked, e-mail us at www.chcradio.com. We'll have FactCheck.org's Lori Robertson check it out for you here on Conversations on Health Care.

[**Music**]

Margaret Flinter: Each week Conversations highlights a bright idea about how to make

wellness a part of our communities and everyday lives. While the world grapples with a global pandemic, public health experts have been simultaneously battling another ongoing health threat. Mosquitoes are considered one of the deadliest animals on earth leading to hundreds of millions of illnesses and some 2.7 million deaths per year globally. Diseases such as malaria, dengue fever and Zika are on the rise.

Dr. Scott O'Neill: There is this one mosquito called Aedes Aegypti that transmits a range of different viruses to people. They include viruses like yellow fever, dengue fever, Chikungunya, Zika, and the consequences can be very dire from a loss of life through to crippling social and economic cost.

Margaret Flinter: Dr. Scott O'Neill is the Director of the World Mosquito Program, which has developed an innovative approach to eradicating the threat.

Dr. Scott O'Neill: I was particularly interested in this bacterium called Wolbachia. This bacteria is present in up to 50% of insects naturally, but not this one mosquito that transmits all these viruses. When we put the bacterium into the mosquito the viruses couldn't grow any longer in the mosquito. We're seeding populations of mosquitoes with our own mosquitoes that contain Wolbachia. We're able to spread the mosquitoes across very large areas very quickly. Once the mosquitoes have it they're protected from being able to transmit viruses. When they're protected, the humans are protected as well.

Margaret Flinter: Dr. O'Neill's team released the genetically modified mosquitoes into a targeted area and the results showed a dramatic reduction in human infections.

Dr. Scott O'Neill: In Northern Australia we deployed the Wolbachia over quite large areas, entire cities, and we've seen essentially a complete elimination 96% reduction in dengue in those cities. We believe if we can scale this intervention across entire cities, we can completely prevent the transmission of diseases like dengue, Chikungunya, and Zika.

Margaret Flinter: The World Mosquito Program is one of six finalists in the MacArthur Foundation's 100&Change competition, which awards are $100 million grant to innovative public health interventions.

Dr. Scott O'Neill: We're hoping that over the next five years, we could bring this technology to protect 75 to even 100 million people. We would hope within 10 years we could bring this intervention to 500 million people.

Margaret Flinter: The World Mosquito Program an effective targeted genetic engineering approach to eradicating the threat of deadly mosquito borne pathogens, leading to a dramatic reduction in harm to public health. Now, that's a bright idea.

[**Music**]

Mark Masselli: You've been listening to Conversations on Health Care. I'm Mark Masselli.

Margaret Flinter: And I'm Margaret Flinter.

Mark Masselli: Peace and Health.

Female: Conversations on Health Care is recorded at WESU at Wesleyan University, streaming live at www.chcradio.com, iTunes, or wherever you listen to podcasts. If you have comments, please e-mail us at chcradio@chc1.com, or find us on Facebook or Twitter. We love hearing from you. This show is brought to you by the Community Health Center.

[Music]