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Marianne O'Hare: 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 David Cutler, the Otto Eckstein Professor of economics at Harvard, one of the key architects of major health reform efforts from the Clinton Administration to the Massachusetts Health Law to the Affordable Care Act. He recently completed an analysis for the Journal of the American Medical Association and calculated the expected costs of the American economy from the pandemic will be $16 trillion.

Lori Robertson also checks in, the Managing Editor of FactCheck.org she looks at misstatements spoken about health policy in the public domain, separating the fake from the facts, and we end with a bright idea that's improving health and wellbeing in everyday lives. If you have comments please e-mail us at chcradio@chcone.com or find us on Facebook, Twitter, or wherever you listen to Podcast and you can also hear us by asking Alexa to play the program. Now stay tuned for our interview with renowned health economist, Harvard's David Cutler here on Conversations on Health Care.

Mark Masselli: We're speaking today with David Cutler a renowned health economist, an Otto Eckstein Professor of Economics at Harvard. Also served at the Kennedy School of Government and the T.H. Chan School of Public Health. He's instrumental in crafting the health reform effort under President Clinton, the Massachusetts Health Law and the Affordable Care Act.

Margaret Flinter: Dr. Cutler has served on the Council of Economic Advisers, the National Institutes of Health and the National Academy of Sciences. He is the author of numerous books and articles, including Your Money or Your Life: Strong Medicine for America's Health Care System. And he was named by modern healthcare as one of the 30 people to have a powerful impact on health care. Professor Cutler, we welcome you back to Conversations on Health Care.

Professor Cutler: Thank you. It's great to be with you.

Mark Masselli: Yeah, you know, we enjoyed your piece in the Journal of American Medical Association, co-written with your Harvard colleague, Lawrence Summers. We are really trying to calculate the projected impact of the U.S. economy of the COVID-19 pandemic, and I guess it's fair to say the findings were pretty grim. You warned that based

on the U.S. response to the pandemic or the lack thereof, the pandemic could end up costing the US economy $16 trillion. I think the GDP for 2020 is running to $21 trillion. So really a profound impact. I wonder if you could tell our listeners what metrics you looked at and how you arrived at your conclusion?

Professor Cutler: Yes, happy to. So it's noted, it's about 90% of one year's GDP. So it's a huge number, there are two primary inputs to the calculation that we made. The first one is what will be the lost output from the economy. So there are various macroeconomic models that have been developed over time that show what the economic output forecast is likely to be. So we use models that were out there, in this case from the Congressional Budget Office, which tends to be pretty middle of the road on this.

And they estimate that it will be at least a decade before the economy recovers, and that that will be roughly a trillion dollars of lost output over that decade. So that's about half of the economic loss. The second part of the economic loss is the loss from worsened health. And that is an economic loss just as lost output is, that is lost output means you don't have money to consume things. Lost health means you don't enjoy life.

So we use a very common technique called valuing statistical lives to measure the value of health impairment in three dimensions. One is for people who die. So, we made a forecast of how many deaths there would be by a year from now assuming that death rates remained at a relatively low rate of a few weeks ago rather than the new higher rate. Second is we added in costs associated with suffering among those who are -- who will survive COVID but have long term, particularly respiratory and cardiac impairment. We've observed that with SARS, people have survived SARS people survive acute respiratory distress syndrome, and a variety of other conditions. And then third is we took account of the populations mental health impairment that is, roughly 40% of people in the country now are reporting symptoms of anxiety or depression. And that had been about 10%. And so we said, look, that's 30% of adults who are now reporting symptoms of anxiety or depression, we need to take account of that. So we build in those three pieces, and that works out to about $8 trillion in total as well. So the total gets to be about $16 trillion.

Margaret Flinter: Well, Professor Cutler I really appreciate your focusing on the very real human cost of this pandemic, and I wonder if we could maybe look at just one slice of it around the impact also on the institutions that support people and the healthcare system. Many considered our healthcare expenditures are already unsustainable right before this.

Now we have 250,000 deaths, people who were cared for mostly in hospitals, millions of infections, the testing, the treating, the vaccine production. All of this adds up to another enormous load on our healthcare system and its expenditures that will likely far surpass anything we've done to-date, how do you see the healthcare system being able to respond to these enormous increased demands for expenditures, and at the same time, we also know they've had losses of revenue that they used to be able to count down, so kind of a double sword?

Professor Cutler: Yeah, it's very interesting, because if you look at the healthcare industry, on net spending on medical care is actually lower this year than it was last year and lower than it was in previous years. So for the first time ever, we're likely to finish 2020, having spent less on health care than the year before. And that's because the loss is, in terms of people not showing up for medical care. In March, particularly April, May, June, were so large, that they're greater than the medical care costs that we've spent in terms of treating COVID and preparing for this winter, and, and so forth. So the healthcare industry is really being hit very hard on the one hand by lower revenues, on the other hand, by increasing spending, on necessary PPE, and so on. One of the ways that healthcare responded, which was unprecedented for health care, was that in the spring and summer, healthcare businesses laid off or furloughed, a number of employees, and this almost never happened. Healthcare is virtually immune to recessions and yet this particular time, they really had no choice but to let people go. So it was one of the leading causes of unemployment, unemployment insurance in the spring and summer, was the healthcare industry. Some of that employment has recovered but not all of it. And so there's employment in healthcare still below where it was,

Mark Masselli: You know, I want to pull the thread a little on sort of your modeling. And I think we can stipulate, and you have been very articulate on this that a nationally coordinated initiative of testing and contact tracing would have saved 30 times the expenditure because it would have been better contained. I'm wondering about the vaccine, because it's in the news. Now, we've got two prominent candidates, others in the pipeline as well. Both have announced 95% efficacy rate. We've had Dr. Fauci on the show, and a couple of times during the pandemic, and I know the last time he was on, he was hoping for maybe 60, or 70%, would have been happy with 70% effectiveness. How does the vaccine roll into your model as well? And then certainly, I think the blocking and tackling of testing and contact tracing. Also, I'd love to hear your thoughts on?

Professor Cutler: Yeah, so the vaccine is a super welcome development, the 90/95%

effectiveness is just fantastic. So that is just terrific news for people. One of the key questions is going to be, how quickly can we get the vaccine to people and enough people so that people feel comfortable going back out and doing the things that they were doing and so on? Almost certainly, that's not going to be until spring, summer of next year. So the forecast that we had done that said, you know, what, if the economy remains depressed, and people remain fearful of the virus through a year, that's probably about accurate, hopefully, we will have overestimated a little hopefully, it'll be sooner than that.

In the interim, the question is what to do. And in some ways, what this does is it puts a lot more pressure to say, let's not hurry people back to work now. Because everyone who becomes ill and either dies or has something bad happen to them just months before a vaccine is available. It's just terrible. So it really puts a lot of pressure on saying, let's figure out ways to keep people going but not expose them to situations where, where they are at a lot of risk. Whereas if you thought you were going to have to live with it for a while, you know, for a long - some number of years, you might say, Okay, I'm going to ultimately have to get, you know, address it. So how do I think about it then?

So I think this will --- this raises the value of things like testing so that people can know whether they are positive or not, whether it's --- whether they're at risk of passing the disease on to others or not, contact tracing, and especially isolation and quarantining. So that we can really keep the virus as low as possible until we can get people vaccinated.

Margaret Flinter: But Professor Cutler, I think, you know, from all your years of studying research, you know, the flaws and you know the strengths of the U.S. healthcare system, and one of the weak points that we have been focused on for so long is the issue of health disparities and inequity, both in health and in healthcare, and certainly, it probably shouldn't have come as a surprise to us during this pandemic, that people of color, people who are marginalized economically have suffered probably the hardest consequences in terms of illness and death, and also the least likely to be insured and protected by leave from their jobs and the like. Tell, tell us a little bit about your analysis of the impact of the pandemic on vulnerable populations in particular, and how you see where the health system has sort of risen to the occasion where we fall short, what do we need to do better going forward?

Professor Cutler: Yes, so unfortunately, the pandemic like everything has exposed the rifts in society between the haves and the have-nots, on the basis partly of race, partly socioeconomic circumstance, partly of ethnicity, partly of living arrangements, and so on. And so in some ways, the

pandemic is kind of awakening people to something that was always there. I think the pandemic though, has also brought a couple of other things of interest. One is, I think that probably the care for when people become very ill with COVID is relatively more similar by, for example, race, then is the care for say chronic disease. And so that's a hopeful sign that suggests that the medical system may be moving in a direction, which says, we are going to work together to not tolerate a situation where care for some diseases is much better on the basis of socioeconomic status or race than it is for other diseases and hopefully COVID will invigorate our efforts to do that.

I also think that COVID is sort of showing us many of the social structures that we're going to have to address if we're going to have to address the broader issue of race and health. So for example, people say, well, you know, if you just equalized access to medical care. Well, for COVID, people have sort of equal access, but that doesn't solve everything. And so, and so we're going to have to address issues of housing and employment and living arrangements and medical care access and a whole bunch of things rather than just thinking about kind of one off kinds of policies that might, that were, I think, some of the debate had been beforehand.

I also think that COVID will do one other thing, which is, you know, that with infectious disease, of course, what your neighbor does matters to you a lot more than with chronic disease. So if your neighbor is obese, you can say, well, you know, look, that's my neighbor, and I'm not responsible for my neighbor, therefore, I don't really need to worry about his or her obesity related issues and so on. On the other hand, their obesity now puts you at risk for them getting COVID, and then an infectious disease and then passing it on to you. And so, every city, every country, every state is going to have to think about the fact that they're only as strong as the weakest link, you know, so if I've got a group of people who are more likely to become ill from something that others can then catch, that's a problem right there in and of itself, I may not have wanted to deal with it, but I have to deal with it. So the idea that infectious diseases are still with us, makes us care a lot more about the health of others than if its, all just chronic disease.

Mark Masselli: We're speaking today with David Cutler a renowned health economist, an Otto Eckstein Professor of Economics at Harvard. whose recent report in the Publication of JAMA predicts the pandemic could cost America economy some $16 trillion. You know, professor, I'm wondering if you could help us understand how untreated mental illness exacts such a huge toll on the economy and how you projected that into your pandemic cost analysis. And I ask this because we recently had Pulitzer Prize winners, Nicholas Kristof and his wife,

Sheryl WuDunn who joined us to talk about a book they had written "Tightrope", really pointing out the economic factors driving the rise in suicide and overdoses of death, and you were talking about issues that we're going to have to deal with, and housing is one, but certainly the mental health disparity that we have in this country and how much the COVID-19 pandemic has raised the profile of our need to really start thinking more holistically about how we provide mental health services in this country?

Professor Cutler: Yes, so mental health, excuse me, mental health impairment has gone up enormously since COVID, especially you can tell it's increased from about 10% of the adult population to about 40% of the adult population. And if you look, many hospitals are still low on the number of patients coming in through emergency departments and so on. With the exception of mental illness, which is increasing in prevalence. And there's no sign that mental health is, has gotten any less bad during COVID and the COVID recession than otherwise. It's really, we're very poorly equipped as a country to deal with mental health issues, and COVID is really exposing that. But we have a very individualistic style, a sort of belief of kind of your own actions matter more than social actions. And then when things don't go well, that then tends to get blamed on individuals rather than on social factors. So that contributes to the problem, combined with the fact that historically, we've so under resourced the mental health sector, we've underpaid, we've under done the number of mental health professionals and so on, that we don't have the capacity to treat people. That's making it very difficult.

The good news such as there is, is that the mental health, mental health provision has become enormously online, has gone enormously online. So telemedicine has come into mental health more than any other area of medicine, and that is great news because getting to the mental health professional was always a big deal. And, you know, the difficulties doing that, and all of that. So anything that can be done to reduce the burden on people who need mental health care is great. The bad news is that we still don't have enough capacity to treat everyone who needs it, and so that that remains a big problem.

Margaret Flinter: Well, we would certainly agree with you that a silver lining and it's hard to talk about silver linings and a pandemic. But making behavioral health services much more accessible through your phone, or your computer has been a great step forward. But you know, we see the impact on all the health disciplines, your colleague, Dr. Koh [PH] was with us recently. And he said, okay, another silver lining is nobody knew what a public health worker was before. And now everybody knows what public health is from the epidemiology to the

data scientists, people know where their local health department is, and that those people actually go out and do things like contact tracing. But we've seen the same with the public's recognition of who are our frontline health care workers. And what do they do? You know, not the television series stuff. But really, what does that emergency room physician, that ICU nurse do is now much better known, we think to the American public? And I'm curious what you think the impact of the pandemic, among its many impacts might be on the healthcare workforce? As we go into the future, is it likely to inspire more people to come into healthcare? Is that likely to change some of our education and training models? Maybe more of a public health focus? What's your kind of future gaze on those issues?

Professor Cutler: Yeah, you know, like everything else, I think it has a mixed impact. So on the one hand, people are truly impressed as they should be with the treatment sector. That is, you know, in the middle of a pandemic, where their own lives are in danger, people are going in to provide treatment, and that's just amazing. And they're doing it under incredibly difficult circumstances. And without adequate reimbursement, without any times --- without appropriate adequate protection and so on. On the other hand, you then, if you talk to clinicians, or if you listen to conditions, there are quite a number who are saying, you know, I'm feeling burned out, I may need to retire. I'm not sure I can keep my practice open, because of the reduction in revenues and the increase in expenses. The telemedicine thing isn't going so well because it's so difficult to do. I'm not sure I have the infrastructure to make all this happen. I'm not sure I can manage having children and practicing medical care at the same time and schools are not open and so on and so forth. So I think there is likely to be a wave of even as we're celebrating medical professionals, we may very well also have a wave of healthcare professionals retiring and healthcare organizations merging with other organizations to get out of the practice of medicine by themselves and all sorts of things like that, that are likely to put a lot of strain on the healthcare system, strain on patients, not of course people are doing it not to create strain, but just because that's, that's what has to happen. So I think that it's cutting both ways.

Mark Masselli: You know, I want to play with that thought for a moment, and I do want to acknowledge that you did a great piece on Freakonomics documentary, “The Doctor Will Zoom You In Now.” So there's sort of a crisis, maybe there's an opportunity here, I think you're concerned that the medical health industrial complex or whatever, it's just very hard to move and whether or not telehealth can really be brought in and bring about economies. But in that change, is there an opportunity for some transformation to occur because there were a lot of things in flux, and we simply, we're going to have to do things in

a different way. Telehealth may be a force multiplier, it may not be. But how do you think sort of broadly about the opportunities and the concerns? Dou you think about is this an inflection point for the health industry that might bring about some positive changes?

Professor Cutler: Yeah, of course, all crises create changes, some good, some bad. So that's, so we shouldn't be surprised by that, you know, we before COVID, we worried that the medical sector was too big, that it was too institutionalized, that it was, you know, not effective at dealing with people where they are and so on. And so hopefully, this can cause a reset in some of that. That is, if we said, you know, why is our goal when someone is sick, to bring them to the doctor, where we're, by the way that can make other people be sick? Like, shouldn't our first thought be, let's treat them at home unless we absolutely cannot treat them at home and then we need to see them, you know, sort of things like that. Or, you know, why are we sending this person to post acute care to a skilled nursing facility if they don't need it, if they can be home.

So those kinds of changes would be very, very good. If they lasted, I think some of it will depend on you know, what happens with the reimbursement environment. And some of it will depend on whether the providers can make the IT infrastructure work. But I could well imagine a situation where a few years from now we say, you know, a lot of that care never came back in person. And actually that's really good. And we're saving our most intensive care for those patients who really need the most intensive settings and that's great. That's likely to involve less employment in health care, but it's ---but those people are very skilled, and they can work in many other industries and occupations as well. And we shouldn't spend any more on health care than we need to. So that so -- that's my hope is that some of this will teach us how to survive in a smaller, more efficient healthcare system.

Margaret Flinter: We've been speaking today with David Cutler, renowned health economist and the Otto Eckstein Professor of Economics at Harvard, you can follow his vitally important work by going to scholar.harvard.edu/Cutler, or follow him on twitter @Cutler_econ. David, we want to thank you for applying your keen intellect and scholarly efforts towards the complex conundrum of the economics of the American healthcare system and for joining us again on Conversations on Health Care.

Professor Cutler: My pleasure, thank you.

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Mark Masselli: At Conversations on Health Care, we want our audience to be truly in

the know when it comes to the facts about healthcare 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 U.S. politics. Lori, what have you got for us this week?

Lori Robertson: Late in the presidential campaign, President Donald Trump claimed that state COVID-19 restrictions are a partisan ploy with the Democratic governors purposely keeping their states closed while Republican governors are opening them. But that doesn't square with the facts. For instance, in Bullhead City, Arizona, just across the border from Nevada, Trump wrongly contrasted the reopening actions of both states. In that speech on October 28, the President said “In Arizona you've opened up but Nevada, get your governor to open up your state please.” So by Trump's telling Arizona, which is run by Republican governor Doug Ducey is opened up, but Nevada run by democratic Governor Steve Sisolak is not, but the reality is both states have very similar restrictions.

In late October in both Arizona and Nevada bars, restaurants, movie theaters and gyms were all open but use was capped at 50% of capacity. Jennifer Tolbert, Director of State Health Reform at the Kaiser Family Foundation confirmed to us that the two states were in similar phases of reopening. In fact, Arizona has slightly tighter restrictions in some areas. For example, large gatherings are limited to 50 people in Arizona, but it is 250 in Nevada. Nevada is stricter than Arizona in one respect. Nevada has a statewide facemask mandate requiring people to wear them in public spaces when they come into close contact with others, such as on public transportation or in a business. Arizona does not have such a mandate and leaves it up to local governments to impose them if they want. And that’s fact check for this week. I'm Lori Robertson, Managing Editor of FactCheck.org.

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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.

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Margaret Flinter: Each week Conversations highlights a bright idea about how to make wellness a part of our communities and everyday lives. Daniela Tudor had a revelation a few years ago, waking up on the cold floor of a jail cell, she could ask for help for her drug and alcohol addiction or she

could die. She chose the former. Tudor then launched not only on her own recovery journey but on a broader quest to develop tools that can help all people grappling with addiction recovery to avoid relapse, which is so common, especially in the early days of sobriety, she realized that there needed to be more readily accessible tools for those in recovery to stay connected to their treatment goals. Beyond the 12 step meetings and the talk therapy sessions,

Daniela Tudor: I am in long term recovery. And I went through a four-week inpatient treatment program, where at the end of that four-week program, all I received was a piece of paper that listed an enormous amount of things I'm supposed to do on a daily and weekly basis for the rest of my life to stay in recovery. And I knew that building something on our cell phones that are with us, 24/7, would be a way to bridge that gap and keep people accountable through an app to those activities.

Margaret Flinter: So she founded WEconnect a relapse prevention on the go mobile application that can be downloaded on a smartphone. The platform is designed to keep people engaged in their recovery plan using daily reminders and a reward system for when you perform the tasks that are essential to recovery.

Daniela Tudor: The individual along with the support of our certified peer recovery support specialists are able to input those activities into the app. And when it comes time for that activity to start, you simply check into it, you see at the top of the app, how you're earning your incentives. And by the way, this incentive program is based on evidence based research called contingency management. So it's actually proven to show that it keeps people accountable to their recovery plans or their care plans. The way that we've digitized it and the immediacy of that incentive, keeps people accountable to checking into those activities on the go.

Margaret Flinter: And the digital platform also allows everyone who's connected to the person's healthcare ecosystem to see in real time activities that are enhancing recovery. And also when one might be at higher risk for relapse.

Daniela Tudor: We have trained peer recovery support specialists all across the country, and they get to leverage a tool that we developed called a data dashboard, where they can see in an instance if someone needs additional support or outreach, and that is built through the app, keeping them accountable to those activities and the peer having insights on how they're staying accountable to those activities in real time. So it really allows for this connection of support 24/7 and visibility so that when someone needs that added support, you know, not days or weeks go by which is without this program is what happens, but rather gives insight and gives the option for connection

in real time.

Margaret Flinter: Since the pandemic hit, Tudor says the WEconnect platform has been a lifeline for those in recovery. Those now often cut off during the shutdown.

Daniela Tudor: Actually, when the pandemic hit. Immediately, my heart went out for a while none of us have support meetings to go to any more in person. So we immediately stood up with a set of partners, these mutual aid meetings that are online that are led by certified peers. And within just a couple months, over 200,000 people joined from all states and several countries.

Margaret Flinter: WEconnect, a downloadable app designed by people in recovery for people in recovery to help maintain sobriety with a support system in the palm of their hand, keeping them on track with health goals, staying connected to a care team and avoiding relapse. Now that's a bright idea.

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Marianne O'Hare: You've been listening to Conversations on Health Care.

Mark Masselli: I'm Mark Masselli.

Margaret Flinter: And I'm Margaret Flinter.

Mark Masselli: Peace and Health.

Marianne O'Hare: 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.

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