

Dr. Zeke Emanuel

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Marianne O'Hare: Welcome to Conversations on Health Care. This week we welcome Dr. Zeke Emanuel, Co Author of a New Piece in the Journal of the American Medical Association, written along with other former members of the Biden Administration's COVID team on call for a new strategy to combat COVID. Now here's Mark Masselli and Margaret Flinter.

Mark Masselli: Our guest is a respected physician, health advisor and author. It's his latest writing that's making news. He was a member of the Biden COVID-19 Advisory Team. But now he is and his co authors have gone public with a call for a new national strategy to deal with the pandemic.

Margaret Flinter: Dr. Zeke Emanuel and his colleagues just published their thoughts in the Journal of the American Medical Association, and it's been called The Striking Critique. But we want to focus on his opinions as they relate to the public health sector.

Mark Masselli: Dr. Emanuel, good to see you again. We'll get to the specifics very quickly. But first, what has been the reaction to your perspective? It's been reported that the Biden Administration has ignored the advice.

Dr. Zeke Emanuel: Well, first of all, I would correct the idea that this is a critique. We did not write this as a critique. We wrote this trying to be helpful. You know, the Biden Administration came in, in 2021, January 2021, with a good strategic plan, which they executed that. But as the virus evolves and mutates, you know, our strategic plan has to be updated, and what we were suggesting is an updated strategic plan with an updated goal. The second thing I would say is, whoever's been letting out the rumor that they're – the Biden Administration is hostile to this doesn't know what they're talking about, simply false.

Margaret Flinter: Well, thank you for that, and I think it's always important to reconsider it. Let me – let me say that, from the perspective of a reader, really appreciated the comments that you made and the recognition that time moves on and things change in a pandemic, and they change pretty quickly, sometimes, tell us a little bit about some of the key recommendations then that you've moved forward with. There's a lot of them we'd love to talk about. But I'd like to particularly hear from you about this idea, which doesn't sound entirely new, that our data infrastructure for dealing with a pandemic like this needs a serious upgrade and reboot, who's going to take that on? And where do you think we are with making that happen?

Dr. Zeke Emanuel: Well, first of all, let me say that I think one of the most important things that we do in the set of articles is to emphasize that the idea that we're going to eradicate the Coronavirus here is just false. And we're not going to eradicate with our vaccines, and we're not going to

get rid of it. Like many other viruses and respiratory viruses, whether it's Rhino Virus or RSV or Influenza, we're going to live with Coronavirus. And the real challenge is then to get us to a low state, we're not ready for the endemic state yet, get us to a low state of cases, hospitalizations and deaths, and then live with it in a new kind of normal.

Second, that means we need to change our frame. Our frame can't be just to measure the number of cases from COVID or the number of deaths from COVID. We need a new measure which the CDC hasn't used yet, but which needs to be developed going forward, which is total viral illness burden. How many people get viral illnesses? How many are hospitalized every week for? How many people die because of this cumulative respiratory viral illnesses that represent all the viruses that we confront? And that we say there's got to be a new threshold, we need to think of that like a bad year of influenza, or maybe a little higher, something like 70,000 or maybe a little more deaths per year. So that's the frame. That's what normal would look like. That's, you know, there's still plenty of things we can do to decrease the mortality and morbidity of those illnesses. But it's not an emergency. It's not a pandemic, and it's certainly not 1,500 people dying a day, which is what we have from COVID today. So that's where we should be going and I think that's an important reframing, and when we get to the endemic state, there aren't big surges. We're not getting a million new cases a day or 1,500 deaths. We can go about normal life, dine indoors, not have to wear a mask. But to get there, it's going to require a lot of things. One thing is we need better information on which to act, and that was the whole point of the idea of the proposal regarding a data infrastructure.

Right now a lot of what the CDC relies on, frankly, or more projections and modeling based upon limited data acquisition and not just for COVID but for lots of illnesses. I mean, they don't even measure RSV. We need a whole new framework, and the system, I just got off the call with a senator's aide who was interested in that data infrastructure, what would it take? Should it be at the CDC? Should it not? We need a new whole new government arrangement so that automatically health system, physician offices, labs, download data every day, and we get a public display, right, non identifiable data about where we're having outbreaks, what kind of viral illnesses are happening, how many people are ending up in the hospital, how many people are dying, we really need that data infrastructure. Israel can have it, Britain can have it, we can too. I don't think it should be housed at the CDC for a whole series of reasons. But, you know, in the modern age, with Microsoft and Google and Amazon and Facebook having these data capacities, and many, many other small startups, we really need to be able to do that.

Dr. Zeke Emanuel

Mark Masselli: You know, to be able to do that, it seems to be the one keyword is that we need leadership. And I go back to our conversation we had back in July of 2020, where you were really focused in on what we're lacking is leadership, and that the new – next administration was probably needed a year to sort of unravel all the things that didn't get done. So I want to get back to this issue of leadership, and it's not – it's not personal about the Biden Administration or not, but you said maybe CDC is, is not the best carrier of the torch? Who really will do that? And do – you just mentioned some of the corporate institutions, do you think you're going to see some of this leadership evolve out of our corporate citizens, the larger companies and tech companies as well?

Dr. Zeke Emanuel: First, I don't think that this kind of data infrastructure is not in the wheelhouse of CDC. Their tradition, their culture has not been collect real time data, make sure that data is accurate. Their culture has been quite different, which is get a little representative data, and let's then extrapolate and model, and I think that's the wrong place to go. There's no substitute for real data, and I don't think their culture is going to be the right culture. The point of identifying these corporations that have done, you know, have real time great data collection, I mean, their's real time, it's not like every evening, they get a download, it's like every second or millisecond they know where you are, which store you're walking into, etc. and they can automatically track it. There's not a person tracking it, it's done by their computers.

I don't think they're going to step up and do this, I don't think they should step up and do this. People don't trust them, but a public private partnership that uses their tech capacity and their operations capacity, combined with a public health approach, including things like non-identifiable information, two-factor authentication, so people don't use – my data doesn't go out without me approving it. I think those things are important, and maybe we do need a public private partnership where the public sector guarantees certain things. We're not selling these data, we're not exploiting them for commercial benefit, etc. And the private sector, as it does, in many cases, helps build the infrastructure and make sure that it's first up to 21st century standards and second, easily updatable as technology progresses.

Margaret Flintner: Well, there are clearly a lot of domains that we need to live in, as this pandemic continues, and hopefully, as we begin to suppress it. Part of it's up in the Cloud with data, data infrastructure, and part of it is boots on the ground, and I want to pick up a little bit on some of your comments about the boots on the ground piece. You've talked about the need for much more of a public health workforce, probably at all levels of that public – public health workforce. You've talked about community health workers, which we're so glad to hear you call that

out. You've also talked about very specific groups like our school nurses, in schools, and we would add to that the school-based health centers which is also a national system with nurse practitioners and other healthcare staff on the ground in the schools. How are we going to move that forward? What can your audience or our audience do to please support this call and how do we move from this as a good idea to something that really moves us forward for whatever the next challenges are to come in public health?

Dr. Zeke Emanuel: So one of the things that I've been calling for, for a long time is data is really important, data alone doesn't [Audio Cut 00:10:07], and one of the reasons I think that many of the tech companies have failed when they come in the healthcare is that they don't realize you need what, you know, we in the medical, in effect [inaudible 00:10:17] right, to get the information, and then you got to do something with it and then do something, is not, you know, about the healthcare systems, you know, they can send you an, I mean, the tech companies can send you an app, but that's not doing something. But doing something in healthcare requires people interacting with other people. They can interact virtually or personally, but they have to interact, and the best way to interact, the first level of interaction should be community healthcare workers who are responsible for a defined area, know the people in the area and can help. They can help on infectious disease outbreaks like COVID, but they can need to be able to help on other things. When we have severe heat waves or severe cold snaps, checking in on people who are homebound, making sure meals are delivered to them, making sure when new babies are born that things are going well with the mother. There are lots of things that a public health workforce like community healthcare can do, and it's extremely – would be extremely beneficial in oh so many healthcare ways.

I think that's a kind of effect around, a public health effect around that. We need to begin developing, I emphasize, school nurses, for a whole series of reasons. Firstly, I think we've paid enough attention to our kids and in particular, our lessons, their health and mental health. And school nurses can be very ---we gather these students together, they can be very efficacious in terms of getting out intervention. Finally, if you got viral respiratory illnesses, one of the complications is it tends to exacerbate things like asthma, and other things that can compromise children's learning if they have to leave school to get treatment, and then stay out. Now, if they went to a nurse, the nurse could handle either him or herself or through telemedicine with a physician or nurse practitioner, treating these kids think about probably be easily handled in a short period of time and go back to the classroom and not lose those very, very important learning opportunities.

Dr. Zeke Emanuel

Mark Masselli: Well, I'm very excited, both the idea of a community health worker workforce, I'm not sure if you're thinking modeling that up on an AmeriCorps Program where we train people because we have a sort of a disparate community health worker network across the country. And certainly, you're focusing on schools were so insightful and right to the point, but you also write about the need for an electronic vaccine certificate platform and you support vaccine mandates. Is it best to have students in school even if they're not vaccinated?

Dr. Zeke Emanuel: Look, I mean, I think this is a no brainer. We require all sorts of vaccines to get into school, and COVID is just another one of them. I've also written a long time ago, I can't even remember, you know, probably four or five years ago, calling for the fact that we should require flu vaccines for kids. We have a lot of kids who unfortunately die of flu, and we should, you know, flu vaccine is far from perfect, it's definitely going to get better over the years to come. I think mandating those kind of vaccines is really, really helpful for the country.

Margaret Flinter: I was very happy to see your call out of the numbers of people who died from flu every year. It's always made me a little crazy that we don't emphasize that on a daily basis throughout flu season the way we've been emphasizing COVID and having known those are pretty, pretty impressive figures. But I want to turn to this issue of treatment, you know, I characterize the pandemic as the shock and awe of the first wave and getting up testing and then the gratitude and relief that we had a vaccine. But we also now have some treatments, and I know your colleague on the Biden COVID Transition Board, Dr. Kessler is going to have to decide soon if the government should still provide the three monoclonal antibody treatments that are authorized for early stage COVID. I know there's some research that shows two of them may be ineffective against Omicron, which we think is the dominant variant, what do you advise them to do? What would your best advice be?

Dr. Zeke Emanuel: Well, I don't have all the latest data and I don't want to second guess, Dr. Kessler. But it seems to me you got two ineffective monoclonal antibodies. I don't think there's any doubt that Omicron is the dominant strain of COVID going around, and there are two -- two of the antibodies are ineffective, and by the way, that was totally predictable. It was heavy investment that the NIH made in developing monoclonal so encouraging monoclonal, we knew what's going to be a problem. Way back in January 2021 while we were on the transition team, several of us met with some of these monoclonal makers, and they were guaranteeing, oh, whatever the variant is, ours is going to work, it's -- we knew, you know, viruses evade the treatments that are directed at them, and they mutate, and it was predictable, these monoclonals will stop working. I think it's quite clear that providing

one that works, Vir, I think is what we ought to be doing. You shouldn't provide ineffective treatments, that is called waste, and they're very expensive.

Well, by the way, one of the things I worry about, and I think we say this in the pieces, you've got oral antivirals, that's great. It's a huge breakthrough. But our experience with HIV and many, many other viruses is you use monotherapy, you're going to get resistance quite quickly, you need multi-drug therapy, and so we're going to need many of these oral antivirals and we should be turbocharging our research and development on this. There are a lot of good promising ones in the wings. And then we need to combine them and test the combination to ensure that -- reduce the risk that we will have resistance to a combination of drugs. That seems to me clearly the strategic approach that we need to take. Unfortunate, I mean, I have to say, I'm somewhat more than somewhat disappointed in the NIH being slow to get to that point.

Mark Masselli: You know, just trying to think about the force multiplier of money that will be needed to execute on this strategic plan. I'm wondering if you have a sense, do we have enough resources right now to undertake it, if we don't, what will be needed? And then do you think there's going to be support in Congress, which is having so much difficulty getting things back past like, build back better, and coming to any consensus? What's your sense of the size of the resources that might be needed, and whether or not Congress is going to be able to push that through?

Dr. Zeke Emanuel: Mark, first, I haven't done a cost estimate of these things, and what we have suggested is not a final strategic plan, it is part of a strategic plan. Second, let's keep our eye on the ball of how much COVID has cost the country, trillions of dollars, trillions of dollars, okay. If we're spending a few 100 billion to avoid trillions of losses, last I looked, that's called a good investment. And we got to stop thinking, have to stop thinking of this as spending money instead of investing money. This is an investment, you have a data infrastructure, data is valuable. We all know data is gold, right? It's valuable, even if the government's not monetizing it, other people are going to get insights that are going to save money, and that's critical. So, you know, you ask me about, you know, various things that will cost money. Yeah, they're going to cost money. But, you know, an investment costs money too as long as it produces return, and if we can avoid serious lockdowns, right, if we can get to endemic COVID faster, that's going to save us, you know, economic, it's going to reduce the economic losses, and that's like saving money. And so we have to see a different framework than oh this is just the government spending money, some spending is just spending, a lot of spending is investment, and we need to differentiate those two. One of the key things about this spending on

the data infrastructure, community healthcare workers is they return money by preventing outbreaks, preventing problems that cost more down the line.

Of course, we need a rigorous analysis of how much this is going to cost and give a good estimate. But, you know, if you improve the indoor air filtration systems and air handling systems in buildings, right, we're going to have fewer viral infections, that actually is valuable from an absenteeism and presenteeism perspective.

Mark Masselli: One quick one because you wrote a book about great healthcare systems around the globe, and we've had David Gergen on who's always telling reminded us, Americans have to find American solutions. Tell me what you think the best country is in the globe in terms of dealing with a COVID pandemic and where we might stand against them.

Dr. Zeke Emanuel: Taiwan.

Mark Masselli: Hands down.

Dr. Zeke Emanuel: I don't think there's a discussion about it.

Mark Masselli: Yeah.

Margaret Flinter: Yeah. Certainly.

Mark Masselli: It's their fear of SARS.

Dr. Zeke Emanuel: I mean, they had – they had, look, they're not, not 100 miles off the coast of China. They have a million citizens working in China, right? By all rights, they should have been overrun with COVID, almost nothing, right? Why did they do so well? Well, they had a data infrastructure, they know when people go to the doctor, the day they go to the doctor, they know what they're going for. They cross that information with their – the information of people coming back from China and Wuhan, and they immediately identified them, tested them began to isolate them. Second, you had a – you have a country that trust its healthcare and government, and therefore what the Minister of Health said, people trusted, they followed, right. You don't have to have half the people say we're not getting vaccinated and many people not wearing masks, etc, etc. All of that makes a big difference. Very, very good response. I don't know if they're the best in the world, to be honest.

Mark Masselli: But they're good.

Dr. Zeke Emanuel: It's a really good model, and if we were Taiwan, it would have been a lot better.

Mark Masselli: Yeah.

Dr. Zeke Emanuel

Margaret Flinter: And a really good healthcare system too.

Dr. Zeke Emanuel: Yes, it's very cheap, very cheap. Now, there are many problems, and we probably wouldn't change ours for theirs, but, you know, people who intersect with the Taiwanese healthcare system, they sing its praises. It's true. Hospitals are kind of like graduate dorms, they're very bare bones. But on the other hand, and doctors' work, you know, you don't get 15 minutes with a doctor. They're like a factory. There are lots of problems. But quality is very good and people are very satisfied, and the costs are a third of our costs.

Mark Masselli: Say one last thing, what do you think about this Pan-COVID vaccine, any sense, they were going to the Walter Reed Hospital.

Dr. Zeke Emanuel: We're looking at it and I look, I'm not the expert on that. I've talked to people who are holding meetings and trying to get the latest on where we are in that development. It's certainly something lots of people are looking at, and if we can do it, we will do it. I'm sure. I think that's an area we, the U.S. obviously excels at, and I think, you know, pushing it forward is going to be critical going forward.

Margaret Flinter: Dr. Emanuel, we really appreciate you joining us for this discussion. Dr. Emanuel is the Vice Provost for Global Initiatives at the Perelman School of Medicine at the University of Pennsylvania, his website www.ezekielemanuel.com and you can find him on Twitter at Zeke Emanuel. Dr. Emanuel, thank you so much for joining us on Conversations on Health Care today, for your insights and for your many decades of service to the country and health care.

Dr. Zeke Emanuel: Take care.

Mark Masselli: Alrighty, ciao.

Margaret Flinter: Nice to talk to you.

Dr. Zeke Emanuel: Bye, bye.