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Marianne O'Hare: Welcome to Conversations on Health Care with Mark Masselli and Margaret Flinter. This week we welcome Dr. Joia Mukherjee, Chief Medical Officer for Partners In Health, an organization founded by Dr. Paul Farmer to address deep disparities in global health. He died unexpectedly, leaving a huge legacy.

Dr. Joia Mukherjee: We should never think that we can provide health care as a human right without massively looking at these unequal structures. And Paul called that structural violence.

Marianne O'Hare: Now hear your host, Mark Masselli and Margaret Flinter.

Mark Masselli: We were all saddened by the recent death of Dr. Paul Farmer and the co founder and chief strategist of Partners In Health. Dr. Farmer and his colleagues, pioneered novel community based treatment strategies that demonstrate the delivery of high quality health care in resource poor settings. He wrote extensively on health, human rights and the consequences of social inequality. He is even called a modern-day Albert Schweitzer

Margaret Flinter: Joining us to remember Dr. Farmer's contributions and to help us all think about how to advance his life's work is Dr. Joia Mukherjee, the Chief Medical Officer of Partners In Health, which has the wonderful tagline of "Injustice Has a Cure."

Mark Masselli: Well Dr. Mukherjee.

Dr. Joia Mukherjee: Thank you so much for having me.

Mark Masselli: Yeah. And really, we appreciate you taking the time to talk with us on this really sad, sad occasion. And let's start with your personal memories of Dr. Farmer. What sticks out in your mind?

Dr. Joia Mukherjee: Yeah, I mean, I was just talking with a friend, just before I joined you. And I think what sticks out most is that Paul was incredibly funny and fun to be around. And I think the reason that sticks out so much is that the work of social justice is incredibly difficult. You have to not only minister to the sick and the poor, but you have to really dive in and recognize the history and the reasons for the injustice.

You know, justice itself is really a retrospective concept, you have to understand that harm has been done and what those forces are. And Paul's great gift was to do that hard work with so much lightness and effervescence and he did that really through humor and love. And it was so generously spread to everyone, we all have thousands of inside jokes and pet names for one another. And I think that that bound us together through really difficult times. And it shows the way that you know contributing to social good can be actually joyful, even

in the dark times. And I think that, to me, is what I've been really coming back to over the days since learning of his death.

Margaret Flinter: That is an incredible legacy. And I'm so glad you raised that human, very human component. Thank you for sharing that with us. You know, one of the things we've come to understand is that Paul Farmer reshaped our understanding of what it means to treat health as a human right. And also the ethical and the political obligations that follow once you recognize that. Tell us a little bit about how specifically did Dr. Farmer accomplish that goal?

Dr. Joia Mukherjee: Yeah, I think, you know, we live in a world that has deeply structured inequalities along the lines of race, nationality, gender. And so when I started and many of us, and the sea change, we all witnessed, because of Paul's vision was, there was an acceptance of those structural inequalities as normative and as unfixable. And so the general thought was a country X has $3 per capita for health. And you have to just do whatever fits in that sealing. Rather than asking, why is that sealing there? How do we break through it? And then the most important question of all what is it that the person in front of you needs? So obviously chemotherapy never fell under that sealing of $3. HIV treatment didn't. Palliative care. Orthopedic surgery.

So in accepting that inequality, that economic and social and racial inequality, you will never achieve health as a human right. And so, what Paul challenges all of us to do, even in death is to treat every person as if you would your own family, you wouldn't say well, we have $3 this is all we can do. In fact, I've seen impoverished people walk miles expend huge amount of resources, sell their own assets, home, animals, just to get care for a child. So the $3 is never enough. And we should never think that we can provide health care as a human right, without massively looking at these unequal structures. And Paul called that structural violence. And indeed, it is violent. And I think that is really his greatest contribution.

Mark Masselli: Well, what a nice conceptual model and really framing up sort of the focus of the organization Partners In Health. And I guess it's perhaps an inflection point. I don't know where you all are. But I'm wondering if you could share with us where do you go from here? And how do you keep Paul's promise moving ahead? And can we assume the focus will remain on community health in countries where you serve and not quote parachuting in strategy when disaster strikes?

Dr. Joia Mukherjee: Yeah, yes, you can assume that we will stay and double and triple down in the communities and the countries we work in helping both the communities and the public system. I mean, Paul, really believed in the public provision of health care, not charity alone. But that, you know, the right to health depends on the public provision, strong governance, and community participation, this is really the dialectic of

human rights, that that is so critical. And, and so you know, we will be doing that.

And one of the things I've been saying a lot is that Paul really left us a roadmap, he wrote about what he wanted all of us to do, he spoke about it, he taught it, and he modeled it in his own practice. And so I think we're very clear that our job is always taking care of the poorest of the poor, but at the same time, strengthening government systems, working with communities, and teaching the next generation.

And, you know, he died in a university, where we have worked together with partners on the ground, the University of Global Health Equity in Rwanda, teaching our first class of clinical medical students, he had been there for six weeks. And we know that one of the most important things to Paul and to all of us, in fact, is to really continue to provide formalized long term treatment to improve health care, not only for people, but to assure that their providers are local people who speak their language, who are from their communities.

And so that is what we are committed to doing, care for the sick, training the next generation, and working to build robust public systems and engage communities.

Margaret Flinter: Well, I think a great example of that was some of his work throughout this COVID pandemic. And we remember that one of his major acts was really pushing the Biden administration to drop intellectual property barriers that prevented pharmaceutical companies from sharing their technology and I am sure that COVID is not the only example. We could look at this, maybe share with our listeners, why that still matters? And where does that effort stand today, in a broader way, as you talked about making sure these treatments are equitably available to people?

Dr. Joia Mukherjee: Yeah, thank you for that question. Margaret. Paul, strongly believed that there should be goods in the public common, for things like health, for education, you know, and when we see what's happening with the, you know, a vaccine apartheid, as many are calling it, you know, they're still less than 10% of people on the African continent vaccinated. We know that Omicron probably came from unvaccinated populations as did Delta, as will the next variant.

So most importantly, to us, it is moral for everyone to have the fruits of science, not for those fruits of science to be again, put along these structured lines of inequality. But in addition, it's in our global interest, to work together and collaboratively to end a pandemic, not in a nationalistic way. We cannot be a fortress. We know that. And so, you know, Paul felt very strongly that the scaling up of vaccine production, he was very committed to the plant that is starting to

produce vaccines in Rwanda. He had just visited there on his last trip. And through collaboration with pharmaceutical companies, with governments that we should really expand massively to 22 billion doses actually, the availability of the mRNA COVID vaccine.

Mark Masselli: You know, I will pull the thread on the word collaboration, because it's interesting that he advocated for working with existing power structures, even if they were disliked, such as with the World Bank. But he also felt all right, getting comfortable with discomfort. And how do you and your organization square these two beliefs?

Dr. Joia Mukherjee: Yeah, well, Paul had a term that we've all come to be very familiar with and use a lot, which is the notion of pragmatic solidarity, you can be in solidarity with the poor and really kind of despise the power structure, really be questioning this structural violence in these structured inequities. And yet, when we come face-to-face with someone suffering, we need to get whatever tools we can to help them. And so the pragmatic solidarity says you can critique and work on these bigger systemic changes, but to deliver care, to save, to palliate, you've got to do whatever it takes to get to that.

And so that is our notion is to stay -- remain honest critics, but also try to collaborate, to get the work done at the very human level that it needs to be done. And we've been able to do that. Sometimes it's not easy. Sometimes we have to have, you know, different strategies. But at the end of the day, the most important people to us are the most impoverished people who are sick.

Margaret Flinter: Well, Dr. Mukherjee, I know education is a huge interesting concern of yours. And we know you as the author of the widely used textbook and introduction to global health delivery practice, equity, human rights, and we understand somehow you've also found the time to get a second edition, coming out with a focus on pandemic. So what will our readers learn from you about this incredible time in our recent history?

Dr. Joia Mukherjee: Yeah, thank you for mentioning that. It's, it's something I think a lot about it this time. And I've Oh, yeah, the second edition is out. I think one of the reasons I was asked to write a second edition is, so many of the principles in the first edition of the textbook is how do you build the staff? How do you improve the systems? How do you look at drug supply, all with, with a mindset that you want equity as the end result. And what we saw in the pandemic that was so jarring is that is the failures of even the richest country in the world, the United States. And I think trying to understand that it's not just about money or inputs, it's about systems that are designed with equity in the first instance. And so a lot of it is talking about how do you look at equity? How do you think about collaboration with people from different cultures, different countries? How do you put the poorest people

first?

Had we done that in the United States, we probably would not have the pandemic that we do. And indeed, when Partners In Health was asked to support the Public Health Department in the State of Massachusetts, our big, I think most important contribution is to do contact tracing, not so much. But for each person we talked to, we said, these are the things you need to do to protect yourself and your family. Can you do it? And if the answer is no, then you need social support, food, eviction support, you know, all of these things. That is how you build a program with equity, if you're just telling people information, that's never going to be an equity focused program. And so a lot of the work in the second edition is to say, how do we in a pandemic recognize what has happened with these structured inequities? And how do we fight to deal with that worsening inequity at a time such as this?

Mark Masselli: Well, that's such an important note of having that lens of equity as a focus and also translating that past, its importance, but into really practical terms. Clearly, there's a noticeable feeling of relief across the United States right now as Omicron variant seems to be waning, but how do we keep Americans alert to the pandemics really continuing threat in other parts of the world that have a lack of vaccines and treatment? And we know this is a global need, and I think Americans tend to perhaps be narrow in their focus about what it means to have a solution here.

Dr. Joia Mukherjee: Thank you. I mean, I think if there's one thing that I and many of my colleagues and certainly Paul, lose sleep or lost sleep over in our lives is how do we get people to care about our shared humanity? I mean, in COVID, you'd think that even just the fact that it's a threat, a continuing threat to all of us would work, but we see if that doesn't work, that's not enough. And what I've seen, in Ebola and HIV and the other pandemics and epidemics I've worked on is the threat of contagion just tends to kind of serve to otherize people, build more walls, close the airports, right.

Whereas trying to bring forth our shared humanity, this is a mother, this is a friend, this is a person whose life has infinite value. That I think is the way we have to go. And I don't see a lot of leadership in that space right now from the global north, but I do see it from, you know, the global south from African leaders, you know, like Cyril Ramaphosa in South Africa, like President Kagame in Rwanda. And so trying to think about how do we foster that.

And what gives me hope, is young people, you know, people under 25, they really understand this in a very different way. I don't know if it's their connections across boundaries. They're, more tuned into the world as their peer group and so it's my hope that that will help us

sort of promote this.

Margaret Flinter: Well, we couldn't agree with you more about our just incredible pride in our young generation coming up and the work that they are doing, and going to do, but one of their challenges as it's been a challenge, I'm sure for your organization has been at any point in time, so much going on in the world right now. What we are witnessing and what people are experiencing so many challenges, how do you prioritize, where you're going to devote your efforts of people and resources? Is it even right to talk about prioritization? Or does the most urgent kind of triage rise to the top of the list, just share with us a little bit about how your organization approaches that?

Dr. Joia Mukherjee: Well, you know, we have the feeling in our very name Partners In Health is that there is no movement that can happen alone, right, that there is no social movement ever that has been a homogeneous group. And so we want to do what we do well, which is take care of the sick. But we invite other people to join us, we have close collaboration with the Equal Justice Institute that is working on, you know, death penalty, reform, and cases. We have close collaboration with Mass Design, which is an architecture group.

We've worked with prison reformers. And so I think if we think that the goal is a better and fairer world, it's going to take lots of different kinds of organizations with whom we are always delighted to make common cause, you know, some of my great friends and fellow travelers, you know, from my life have been HIV activists. You know, so I think the way we look at it, and what I tell young people that I teach, is do what you do well, do what you do with a passion. And then try to find collaborators from different walks of life to share that journey.

And, you know, I am a doctor, and so I try to do doctoring. I also have, you know, I'm a reasonably good speaker. So I end up in front of, you know, crowds, but there are people who are phenomenal at trying to do financing, and they're working on that. You know, there are people who know a lot about water and sanitation. There are people know about peacemaking. And so, you know, that's my view of the world that we all have a part in it, and can work together.

Mark Masselli: Well, that's a great vision. Thank you, Dr. Mukherjee for all that you're doing. And we appreciate your insights into the life and work of Dr. Farmer and also the incredible impact that Partners In Health is having around the globe. And thanks to our audience for joining us in this important talk and you can learn more about Conversations on Health Care and sign up for our e-mail at chcradio.com. Again, thank you so much.

Dr. Joia Mukherjee: Thank you so much. Thanks for having me.

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 U.S. politics. Lori, what have you got for us this week?

Lori Robertson: In late January the Food and Drug Administration pulled its authorization of two COVID-19 antibody drugs because the treatments are highly unlikely to work against the Omicron variant. But Governor Ron DeSantis of Florida misleadingly claimed the decision had been made “without a shred of clinical data” to support it.

There may not be data from patients, but lab studies strongly suggest the treatments will not help Omicron infected people. Since late January, the Centers for Disease Control and Prevention has estimated Omicron accounts for nearly all the Coronavirus infections in the country. The manufacturers of both antibody drugs in question, Eli Lilly and the biotech company Regeneron said in statements that they agreed with the FDA and found the decision appropriate.

The agency said that it would allow the use of the drugs again if another variant comes along that is susceptible to the treatments. The FDA pointed health care providers to treatments that are expected to be effective against Omicron. Those include two newly authorized antiviral pills, the antiviral, Remdesivir and a different monoclonal antibody treatment manufactured by Vir Biotechnology and GlaxoSmithKline.

On February 11th, the FDA authorized a new monoclonal antibody manufactured by Eli Lilly, that does retain activity against the Omicron variant. That means that while the agency revoked the authorization of two monoclonal antibody treatments, there are two other monoclonal antibody treatments that are authorized for use against Omicron. The state of Florida and its Republican governor however, we're critical of the FDA’s late January move to revoke the authorization for some antibody drugs. DeSantis said in a January 25 tweet that the decision had been made “without a shred of clinical data”, calling the drugs life saving treatments.

Again, while there may not be studies in people demonstrating that the two antibody treatments are now useless, there's an abundance of other data including from the companies that suggest these drugs have little if any ability to fight off the Omicron variant.

Since September, the federal government has been supplying COVID-19 monoclonal therapies to states based on the COVID-19 caseload and how much a locale has been using the drugs. These synthetic

antibody treatments target the spike protein of the SARS CoV-2-virus and can prevent it from entering cells.

Earlier clinical trials showed the antibody cocktails which are either infused intravenously or injected under the skin reduced the risk of hospitalization or other negative outcomes in high risk outpatients. That led the FDA to authorize them for non hospitalized patients with mild to moderate COVID-19 who are at high risk for developing severe disease. As with any COVID-19 treatment, the monoclonal are not a substitute for vaccination. But the shape of the Omicron variant spike protein is different. And some of the antibody treatments can't neutralize the Omicron variant very well, if at all, as numerous lab studies have shown.

For instance, a January Nature Medicine study found the Regeneron and Eli Lilly antibody combinations lost all neutralizing activity against an Omicron virus taken from an infected American. But as we said a different monoclonal from Eli Lilly has now been authorized for use against Omicron. Regeneron is preparing to begin clinical testing of another antibody treatment. That's my fact 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 as a project of the Annenberg Public Policy Center at the University of Pennsylvania. If you have a fact that you'd like checked, email us at chcradio.com. We'll have FactCheck.org's Lori Robertson check it out for you here on Conversations on Health Care.

Mark Masselli: Each week Conversations highlights a bright idea about how to make wellness a part of our communities and everyday lives. One in five Americans will suffer a diagnosable mental health condition in a given year, and most often don't seek treatment. For those with serious mental health conditions the consequences can be devastating. Seeing a rise in mobile apps aimed at behavioral health entering the marketplace, a University of Washington researcher Dror Ben-Zeev thought a comparative effective analysis study would be a good idea.

Dror Ben-Zeev: My team and I conducted a three-year comparative effectiveness trial, now with the objective of having a head-to-head comparison between a mobile health intervention for people with serious mental illness called FOCUS and a more traditional clinic based group intervention called WRAP or Wellness Recovery Action Planning. So it's conducted at a clinic setting, people with similar diagnoses. So the study really gets at some of the core differences between mobile health and clinic based care. Is there something about the mobile health approach that would make it more accessible or less accessible when people find it less engaging over time?

Mark Masselli: More than 90% of the mobile App group engaged in the online program, which was a series of text messages, offering coping strategies and self monitoring of symptoms, along with weekly call-ins with a behavioral health clinician.

Dror Ben-Zeev: The second thing we wanted to see is after people complete care, what are their subjective ratings of their experience and treatment? Are they satisfied with both interventions? Are there differences in their levels of satisfaction? And probably the most important piece of the study are the clinical outcomes. So we measure to see whether involvement in both interventions for a 12-week period, would that create some sort of difference in psychiatric symptoms severity and quality of life, and 90% of the individuals who were randomized into the mobile health arm actually went on to meet a mobile health specialist to describe the App to them and train them how to use it and used the intervention App that's assigned to them at least once. Whereas in the clinic based arm, we saw that only 58% of the participants assigned to that clinic based intervention ever made it in for a single session.

Mark Masselli: Both groups of patients saw roughly equal results from their completed treatment, but the mobile group was more likely to engage in therapy. Ben-Zeev says this suggests that mobile therapies may provide a useful tool for clinicians having trouble getting those with serious mental health issues, to engage with the clinical interventions.

Dror Ben-Zeev: The group dynamics, the fact that there's a sense of shared experience and perhaps even normalization of some of the experience that on its own is quite potent for people, right. And so we know that the very existence of a group can be quite helpful. But for others, the interaction is anxiety provoking, just making it to the clinic to engage in that interaction is logistically complex. When it comes to the clinical outcomes, in both intervention arms people improved, both in terms of reduction in their symptoms and the distress associated with symptoms and improvements in their recovery.

Mark Masselli: The results of this study were published in the Journal of Psychiatric Services, a targeted mobile App aimed at facilitating access to clinical care for those experiencing serious mental illness symptoms, proving equally effective and managing the condition improving access to intervention for behavioral health needs. Now that's a bright idea.

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.

Margaret Flinter: Conversations on Health Care is recorded at WESU at Wesleyan University, streaming live at 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.