**Fixing Healthcare Podcast Transcript**
**Dr. David Blumenthal**

J. Corr: Hello, and welcome to Season 3 of the Fixing Healthcare podcast. I am one of your hosts, Jeremy Corr. I'm also the host of the popular New Books in Medicine podcast. With me is Dr. Robert Pearl. For 18 years, Robert was the CEO of the Permanente Group, the nation's largest physician group. He is currently a Forbes contributor, a professor at both the Stanford University School of Medicine and Business, and author of the bestselling book Mistreated: Why We Think We're Getting Good Health Care - and Why We're Usually Wrong.

R. Pearl: Hello everyone, and welcome to the new season of our monthly podcast aimed at addressing the failures of the American healthcare system, and finding solutions to make it, once again, the best in the world. In this, our third season, we turn to the world of politics.

R. Pearl: As always, we'll be looking through a nonpartisan lens as we examine this critical question: What should be the role of the U.S. Government in healthcare? We invite you, the listeners, to share your thoughts on this topic. Please take the new Fixing Healthcare survey available on my website, robertpearlmd.com. We'll be reading and discussing the best listener suggestions throughout Season 3.

J. Corr: Our guest today is Dr. David Blumenthal. David is a healthcare policy expert and president of the Commonwealth Fund, a national philanthropy engaged in independent research on health and social policy issues. His career spans medicine, politics and academia. He is a former primary care physician, director of the Institute for Health Policy, and professor of medicine and health policy at Harvard Medical School.

J. Corr: Under the Obama Administration, David served as the national coordinator for health information technology, in charge of building a nationwide health information system and supporting the meaningful use of health IT.

R. Pearl: Welcome, David. We're thrilled to have you on the show.

D. Blumenthal: Good morning.

R. Pearl: This is the first episode and our third season of Fixing Healthcare. In the first season, we invited experts from within the current healthcare system, and asked them to offer their views on how we could improve quality and access by 20%, lower cost by 20%, and increase satisfaction both for physicians and patients by 20% over the next few years.

R. Pearl: Their ideas were powerful and inspiring; but as you know, strategy without implementation is powerless. So in Season 2, we looked at approaches from outside the healthcare mainstream. We interviewed experts in system redesign

implementation and disruptive change. In the current Season 3, we're focused on the role that government can play, and I can't think of anyone better able to offer insights based on broad personal experience than you.

R. Pearl: So let me begin with an overarching question. What do you believe the role of government should be relative to the health and healthcare of the American people?

D. Blumenthal: Right. It's great to be joining you, Robbie. You've asked a very fundamental question. My views are that government has the ultimate responsibility for assuring that all Americans... in fact, all citizens and residents of every polity... have access to affordable healthcare and high quality healthcare. I also think government is uniquely suited to do research and development and to lead the implementation of innovative ways of improving the delivery of healthcare services. And in doing so, to find ways to stimulate and promote innovation in the private sector, while also providing leadership.

R. Pearl: Can you be more specific as to how you see government getting involved in the provision of healthcare coverage?

D. Blumenthal: Well, I am agnostic as to the precise mechanism. I think that in this country, the likely path we will take is to have guaranteed private insurance, high-quality private insurance, accessible and easy to use private insurance for all Americans. I say that not because I think private insurance is preferred to public, but just because I think that is the momentum in our healthcare system, and the way in which Americans think about the provision of healthcare.

D. Blumenthal: In other countries, the public provides coverage directly. In some other countries, not in all, but in some. But there are many models, in Europe and elsewhere, in which the government regulates private carriers, and they sell insurance in a competitive insurance market, but do so within the boundaries of regulated market to ensure that there is coverage of preexisting conditions, that there is adequate coverage, that the cost sharing is affordable, and that the full range of necessary benefits are covered.

R. Pearl: How about in the arena of drug development and pricing?

D. Blumenthal: We have a system in the United States, which right now is tipped toward what the pharmaceutical industry likes to call innovation, what others might call protection of intellectual property and exclusive rights to new intellectual findings. That balance is not stable at the current time. We are producing very, very important new chemical agents and new approaches to curing illness, which are devoutly to be appreciated; but we're doing so right now at a price that is making these findings inaccessible to large numbers of Americans, and which are going to be unaffordable for the society as a whole.

D. Blumenthal: So we need to find ways to make them affordable. And I think that means moving away from some outdated protections of intellectual property; some, for example, associated with the Orphan Drug Act, and also some of the abuses of patent law that have arisen as pharmaceutical companies try to protect their intellectual property.

R. Pearl: The Commonwealth Fund has done an amazing job of highlighting both the high cost of American healthcare and the low quality compared to the other industrialized nations of the globe. Where do you see the government directly intervening in the care delivery system itself?

D. Blumenthal: The government is a source of enormous innovation, underappreciated in the payment for healthcare services. I think they have been leading and will continue to lead in the creation of effective methods for holding providers accountable for cost and quality; something that goes by the euphemism of value based payment.

D. Blumenthal: But I see the government leading us in this country toward more and more risk sharing with providers, in ways that the private sector seems either reluctant to do or incapable of doing. And so, I think that as DRGs, for example, in which hospitals hold some risk for the cost of hospitalizations, MACRA, the recent changes in how physicians are paid under Medicare, which allows physicians to adopt alternative payment methods that involve risk-sharing, more aggressive downside risk in accountable care organizations.

D. Blumenthal: These are all positive developments that are leading toward risk sharing in a way that will, I think, moderate the tendency of providers to do more than is absolutely necessary for the care of patients, and will also change the dynamic around pricing, so that increasing prices is not as easy and profitable for providers as it has been in the past.

R. Pearl: How about in the area of regulating, limiting prices in hospitals, doctors, and ancillary services like laboratory and radiology?

D. Blumenthal: Right now we have two systems for setting prices in the United States. One is the private sector, in which insurance companies negotiate with independent private providers. And the other is the public sector, notably Medicare and Medicaid, in which either state or federal governments administer prices, set them in some kind of negotiated process, or more direct administrative process with the private sector.

D. Blumenthal: So if the private sector is going to continue to have the freedom to negotiate prices, they're going to have to find ways to make that negotiation fair and more predictable. And that means making the prices transparent, that is making them public, and presenting them to the public in a way that is understandable and helpful for decision making by purchasers, whether they're consumers or employers. Right now we don't have that system.

D. Blumenthal: So unless the private sector finds a way to accomplish that, we will feel increasing pressure to have the public sector intervene to set prices. I don't think we will accept that politically. We have gone a long way down the line of making prices more apparent and transparent, and presenting them in a way that's understandable and actionable. And I think that's the next agenda, and I expect to see more and more of that over the next three to five years.

R. Pearl: Is there an approach that you'd recommend that we take as a country?

D. Blumenthal: If we wanted to control costs, the most effective way and certain way of doing it, would be to set prices the way every other country in the world does, in negotiation with providers. I don't think we will do that. What I prefer is that we get on as fast as possible and as assertively as possible with price transparency and with the presentation of prices in ways that are, as I said, understandable and actionable.

D. Blumenthal: That does not mean unrestricted, unregulated, spontaneous price transparency. It means price transparency probably in the nature of episodes of payment in local markets, episodes of care of the type that make sense to people and make sense to the people who buy insurance, who are laypeople who work for employers, so that insurance companies and providers can be held accountable.

R. Pearl: I've taken the position in some of my Forbes articles that there's a cost shifting going on with Medicare having ability to arbitrarily set prices and setting them below at least the current costs of the providing the care, and that the commercial segment is bearing the brunt. Others have said that they disagree. Do you have a point of view about the relative balance of the federal payments against the commercial ones?

D. Blumenthal: My economist colleagues do not believe that there is such a thing as cost shifting. And I think the rationale for that is that, as long as providers can raise prices to private payers, they will do so. And their ability to do so has nothing to do with their cost, it has everything to do with their revenue aspirations. And that they could easily live within what Medicare pays. And indeed, some do.

D. Blumenthal: So I do think, having spent a good deal of my life working in healthcare systems, I do think that there is a tendency to spend up to what you can collect. That is that organizations, if they can make more money, will find ways to spend it. That's not necessarily to say that it's wasted or that it's not socially useful, but it doesn't necessarily reflect their costs of doing business. It reflects their aspirations for improvement. I think that that is not in my view totally cost shifting, it is a symptom of a noncompetitive market on the private sector side.

R. Pearl: I like that explanation, David. Thank you. How about the role of government when it comes to privacy and security of patient data?

D. Blumenthal: Government needs to assure privacy and security. I think the private sector needs to implement the assurances. There need to be clear penalties for failure to protect patient data. I don't think that HIPAA is the right framework. It does govern the behavior of organizations, but it doesn't govern the use of information per se. That is, if you're not a covered entity, you have no requirements to keep patient data or patient information private and secure.

D. Blumenthal: That is a huge problem in the Internet age and in the social media age. Lots of organizations that will soon be managing intimate patient data are not necessarily covered entities, and not regulated under HIPAA. It is a daunting prospect for the government to wander into that field, but it is going to have to. We will watch and wait for a series of scandals to erupt that will create public political pressure on Congress and state legislators to act in this domain.

D. Blumenthal: The way this usually happens is that states start. They start regulating unregulated entities within their boundaries. I would expect large pro-government states like California, New York, Massachusetts, Michigan, maybe Colorado, to begin this process. And at some point the companies that are regulated are going to throw up their hands and ask the federal government to step in and create consistency across states. That's what usually happens with this kind of phenomenon.

R. Pearl: How about when it comes to conflicts of interest, either by physicians or by researchers? Obviously the Sunshine Act shone some light on that. Do you see a greater role that government should take in these areas?

D. Blumenthal: I think right now the use of transparency needs to be allowed to unfold. The NIH, I suppose, is perhaps the most benign pro researcher side of the government. And I think that having the NIH set some boundaries around what's acceptable in conflict of interest is probably as effective as anything else, in terms of what kinds of conflicts are not acceptable in getting research funding.

D. Blumenthal: We've been down this route now for 20, 25 years. In the 1980s and 1990s, a lot of universities created conflict of interest policies that were quite sufficient. Many of them still have them. So I think that what we're seeing now is, in a couple of very dramatic cases like Memorial Sloan Kettering, is laggard institutions that never got around to adopting those policies, or that have stopped enforcing them.

D. Blumenthal: So I think NIH needs to just remind organizations of what their responsibilities are, and make sure they have them. I think the MMC also has a responsibility to bring its members back into a compliance with rules that they had encouraged them to adopt 15, 20 years ago.

R. Pearl: Yeah. I had a chance to watch your PBS interview, I think from 2002 about this issue, and your insights then were quite prescient and worth watching for

anyone who's interested in this particular part of the healthcare delivery system. How about the out-of-pocket maximum costs? We know that today, half of people can't afford to pay their full out-of-pocket costs were they to incur a serious illness. Does the government have a role in protecting Americans from unaffordable out-of-pocket expense?

D. Blumenthal: Yes it does. The private market will not do that. Most western countries have a maximum out-of-pocket cost on an annual basis, and protect their citizens from cost in excess of that. I think it would be helpful if the federal government actually did that under the Affordable Care Act in the individual market. If we had a universal private sector regulated universal healthcare system, I would expect it would include an out-of-pocket spending maximum.

J. Corr: Medicare for all is something that a lot of people are talking about as a way to help fix American healthcare. Do you think a move towards Medicare for all is realistic? If so, how long would it take, and what would the roadblocks be?

D. Blumenthal: I don't think it's politically realistic. And I say that having been involved in multiple efforts over my career to enact a conference of National Health Insurance. I don't think that the American Congress is in business of putting industries out of business. I don't think that they're going to force the insurance industries to close shop. And I think that the prospect of ripping insurance away from 160 million, 180 million Americans is an insuperable political obstacle to Medicare for all. That says nothing about the merits of the idea, it's simply a political judgment. I think there's zero chance that it will be enacted in my lifetime.

D. Blumenthal: By the way, the one exception to that might be if we had a great depression or a Third World War. That is a catastrophe so unimaginable that it'd totally changed political calculations.

R. Pearl: You've done a great job, David, of outlining what you see to be the role of government. The listeners to this show, quite a number of them are healthcare professionals, quite number of others are business experts, very few of them have the breadth of experience that you do. So I'd like to shift now from the role that you see government to play, for your ability to help us understand actually how does the government work.

R. Pearl: And so let me start by saying that early in your career you served as a staff member to one of the Senate's subcommittee, if I remember right. What did you learn about the legislative process at that time, and how could it be applied today?

D. Blumenthal: Well, I worked for Senator Edward Kennedy. I'm from Massachusetts, at least I've lived in Massachusetts most of my adult life, and I had the chance to work for him. He's now, of course, deceased, but at that time he was a fairly young man. I didn't seem young at the time, but I was much younger still. And working

in the Senate was a really extraordinary experience, especially working for Ted Kennedy.

D. Blumenthal: He was a complex person, a complex individual, especially earlier in his life. He had a number of personal faults that he later managed much better. But one thing he always was, was restless intellectually and profoundly committed to improving healthcare. Unique in the Senate, unique in the Congress; was truly a thought leader in the Congress on healthcare.

D. Blumenthal: So it was a great privilege to work for him. I learned a couple of things. One thing I learned is that the congressional process is remarkably porous. It is designed to make it possible for citizens to approach the process. The doors are always open, especially to constituents of senators and congressmen.

D. Blumenthal: And so, despite the appearance that it is dominated by private stakeholders of power, there is a great deal of opportunity for people to participate. So I guess that was one the thing I learned. Another thing I learned is that senators and congressmen are pretty representative of the people that elected them. They're laypeople. They are not sophisticated in their understanding of technical issues, whether it's transportation, or energy, or health, and that to convince them of a policy, you have to reduce it to understandable lay terms, which provides kind of a check on the power of professions.

D. Blumenthal: Professions may not like that, but it is the essence of democracy to require that the public understand what it's representatives are being asked to do. And one way to make sure the public can understand it is for them to elect people who have the same level of comprehension and same perspective that they do.

D. Blumenthal: So I learned that the congressional process is porous. I learned that it is populated by people who are not always expert on the matters before them. That means that they can be carried away by powerful stories that are not representative of the facts. And it puts a huge burden on professionals to be understandable, and to express themselves in ways their... in fact, their patients if they're health professionals, could understand.

D. Blumenthal: And that is an enduring challenge given the complexity of healthcare issues. And one of the frustrations for experts and for professionals is and always will be that the policies that come out of government often seem simplistic. But that is in part because the understanding of the issues is necessarily... falls short of the complexity of the issues. It's just very hard to get across to laypeople the complexity of the issues that have to be dealt with.

R. Pearl: Both in the presidential campaigns of 1988 and 2008, you served as chief health advisor to a candidate. What can you tell us about the process of becoming the chief executive for the nation, and the role the president should play once elected in advancing the health of the country?

D. Blumenthal: Well, for most of my career, health was a relatively low priority issue for Americans and for candidates. So I learned in 1988 and in several subsequent campaigns that I participated in before President Obama's campaign, I learned to be humble about healthcare. I learned that those of us who spend our lives in it vastly overestimate how important it is to the American public and to the electorate. And if it's not important to the public and the electorate, it does not assume the same level of importance that we might like it to have with people running for office.

D. Blumenthal: So humility is one thing I learned. Another thing I learned is that, consistent with what I was saying earlier about public understanding, when you are trying to convince people that you are the candidate they should vote for, you have to convey your ideas and your thoughts in ways they can understand, and that respond to their concerns. And that is a big challenge for advisors in every area, whether it's trade, or banking, or taxation or whatever, and it is a challenge in healthcare.

D. Blumenthal: So I learned how important it is, as I suggested earlier, to find ways to express healthcare policy ideas in ways that are intuitively understandable to people. Doing that, and at the same time undergirding it with responsible policy is a challenge. It's a lot of fun if you enjoy that thing, but it's also a big challenge.

R. Pearl: In 2009, President Obama appointed you to be the national health information technology coordinator. I think it was about a month after the passage of the HITECH legislation, the bills that offered, I think $19 billion in incentives to physicians to buy computer systems, as long as they did it for meaningful use. You served in that role until 2011. What was it like to take on this awesome responsibility, and how would you view the evolution of health IT across the United States since then?

D. Blumenthal: Well, if we had a few hours, I could probably make a dent in explaining that. But it was, of course, an honor to do that. It was also not a job I sought. I'm not a technologist. I am not someone who's consumed with... I didn't start building computers in a garage when I was a teenager. I don't program. I don't know any programming languages, and I don't have any intuition for computers or software.

D. Blumenthal: What I had going for me was that I was a physician continuing to practice primary care, working in a tertiary care center, attending on the inpatient service as well as seeing patients in the outpatient service. Of course, I had done my stints as moonlighting in an emergency room and so on. I'd worked in community health centers.

D. Blumenthal: So I had a pretty broad clinical experience, and I had also used an electronic health record at Mass. General Hospital where I worked. And I had done some research as a health services researcher on adoption of electronic health records, so I knew what some of the barriers were. So all those things gave me some perspective.

D. Blumenthal: And the last thing I had, which again was I think different from many of the other people who have taken on this role was, I was a student of government. I had taught for seven years at the Kennedy School. I had written a book on how presidents manage healthcare policy. I understood, intimately, how the Department of Health and Human Services works, and how it relates to the White House and the various groups that work in the White House. So I actually felt incredibly well prepared for this responsibility, much more so I think than I would have been if I had come without those set of experiences.

D. Blumenthal: I think the lack of technological knowledge was actually a benefit, because I could identify with how bewildering it would be to ask hundreds of thousands of physicians and thousands of hospitals to drop everything and start using electronic health records, despite the availability of money to encourage it.

D. Blumenthal: I spent two years there developing the policies and the frameworks that became part of HITECH, and that persisted for about 10 years, until some of them were superseded by other payment legislation, particularly MACRA. And there was a very complex dance that we went through to make viable policy; a policy that would survive scrutiny in the Congress, in the White House, in the Department of Health and Human Services, at OMB, and with the professions and with the public, all important stakeholders.

D. Blumenthal: It's a long story, but it was a big challenge but also an enormously gratifying, because I had a lot of independence, I had a lot of resources, and I gained enough trust so that I was allowed to do what I thought was right most of the time. What I thought was right was not always what was perfect or ideal, but what was possible on the way to something that would get better over time.

R. Pearl: I've heard you speak about the power of data to improve quality. Certainly we know that computers can provide patient convenience. Theoretically, they should be able to lower costs. They should be private, secure, interoperable; all the various terms that are there. Where are we in the healthcare IT evolution, and I'll say "revolution".

D. Blumenthal: Yeah. Well, I know Robbie, that you worked at Kaiser for most of your career, and I also know that Kaiser was an early adopter and a pioneer. There's, I think, a very important lesson from that. But I'm not going to dwell on that. Let me say that electronic health records are a technology. And we know over the history of the human race that technologies do not control the development of humans, humans control how technologies are used. They put them to use for their purposes.

D. Blumenthal: And that is true. Nuclear energy can be used to destroy humanity or to generate green energy, and to power nuclear submarines, and to power interplanetary exploration. The technology itself does not control the destiny of the sectors in which it operates. And I think that would be true of electronic health records.

D. Blumenthal: If we prioritized quality and cost control as the most important priorities for our healthcare system, electronic health records, A, would have been adopted without government incentives, and, B, would be very different than they currently are. They would have been developed with those goals in mind, rather than as they were, with the goal of recapitulating the paper record and assuring in the process that revenues for organizations were maximized.

R. Pearl: When George Halvorson and I, he as the head of the health plan and myself as the head of the medical group, made the decision to put in place a comprehensive system of IT, that we'd have information available at every point of contact. We were, as you say, functioning in Kaiser Permanente, which is a fully capitated, prepaid-type system, and so the kinds of considerations you're describing didn't exist.

R. Pearl: And yet, it was so clear that if we're going to put in place approaches to raise quality and lower cost simultaneously, it couldn't be done without health IT systems. The question I have for you is, will we be able to utilize the IT systems to the maximum in a fee-for-service type world?

D. Blumenthal: Fee-for-service will always distort the use of electronic health records. Realizing the full potential of electronic health records requires a change in the way we pay for care, and changing the way we pay for care requires the use of electronic health records. So they are intertwined. Their fates are intertwined. I hate the chicken and egg cliché, but it applies here.

D. Blumenthal: You can't be an effective risk-managing organization in taking care of patients without good information, and prompt and valid information, and you can't have that information in a paper world. So we need good information systems. And our studies here at The Commonwealth Fund of systems that effectively manage high cost patients, IT is a critical, foundational component for success. You need to have the environment of shared responsibility for cost in order to motivate, not only adoption of IT, but its re-purposing to the end of managing cost.

R. Pearl: Your book Heart of Power: Health and Politics in the Oval Office, offers poignant insights into the interplay of elected officials personal health issues and their legislative agendas. Can you tell our listeners what you learned from your research, and a few of maybe the most memorable stories?

D. Blumenthal: Yeah. It's very interesting to watch the interplay in the book you mentioned. I wrote it with a political scientist, and I came to it as a physician with a deep interest in government. But I had the intuition that the personal health of presidents would influence how they regarded healthcare as an issue. And I found that to be true; in some cases, very directly and very poignantly. I also found there were times when it wasn't true.

D. Blumenthal: One time when it wasn't true was with Franklin Delano Roosevelt, who of course suffered from polio, was partially paralyzed his entire life, though it was hidden from the American people; was actually an enormously innovative, what would be now called physiatrist. He developed rehab programs that were totally novel for their day, as he tried to work with his own paretic and spastic limbs.

D. Blumenthal: He actually crashed at one time a meeting of the American Academy of Orthopedics, to try to get them to adopt some of his ideas. But he never was an aggressive advocate of universal health insurance despite his own disability, and that's an enduring puzzle for me. He always got close and then backed away from advocating what Harry Truman later advocated.

D. Blumenthal: Another really interesting example of how personal health experience influenced a president's decision making was the case of Richard Nixon. Richard Nixon's family was riddled with tuberculosis. He himself probably had the disease; and though it was not clinically prominent, it was prominent on his own X-rays, but he had siblings who died of it. His mother took brothers from his home in Whittier, California to Arizona for treatment of tuberculosis unsuccessfully.

D. Blumenthal: And later on when he was president, he was a very forceful advocate for universal health insurance. And when speaking about it, he often referred back to the healthcare experiences of his childhood and his mother's caring role for his brothers, the financial burdens that they had to deal with.

D. Blumenthal: One other person who was influenced very directly by the healthcare experiences of their family was John F. Kennedy. Kennedy became a Medicare advocate after his father had a stroke. Joseph Kennedy had a devastating stroke while Kennedy was president.

D. Blumenthal: And when Kennedy began his personal campaign for Medicare, and he worked very hard to get Medicare passed unsuccessfully before he was assassinated, he also referred to his father's personal experience and the cost of caring for him, and how fortunate they were to have the resources to do what was necessary to care for his crippled father.

D. Blumenthal: So there is definitely a relationship. There is no such thing as protection against disease and illness, either personally or in families, and presidents are as vulnerable as anybody else and their personal experiences can make a difference. President Obama's mother's illness is often cited as a reason why he was so committed to the Affordable Care Act, even though he was advised not to do it by virtually all his advisors, including Vice President Biden.

D. Blumenthal: And it's not clear to me that from a strictly political standpoint it was wise for him to advocate the Affordable Care Act and make it the priority he did. And I think it's a mystery that remains to be solved to understand exactly why he

made that commitment. His mother's illness is an easy explanation. I don't know for a fact that that's the correct explanation.

R. Pearl: Fascinating. It helps explain why Richard Nixon was the force behind actually the HMO Act passed in the late 1970s, and Kennedy certainly led the areas of disabilities and mental health benefits. So it definitely all ties back into their families and their personal situations.

R. Pearl: David, the government today, I think most people would call overly partisan, different than the past, different than when you were working with congressional leaders. Do you have ideas and hopefully some optimism for the future about how the current situation might get resolved?

D. Blumenthal: Well, I'm not an American historian, but I do know from the historical reading I've done, that there have been other times in our history of intense partisan conflict, including in the early decades of our country when political parties first formed and when Jefferson and Hamilton were fierce contestants for political power, then Adams and Jefferson also we're fierce contestants.

D. Blumenthal: And, of course, in the time before the civil war, partisanship was incredibly fierce and had the consequences that it ultimately did. So I don't think that this period in history is unique, but I do think it's at the extreme end of the spectrum of partisanship, the distribution of partisanship that we see over the course of our history.

D. Blumenthal: I personally think it reflects deep demographic and sociological developments in our country, the increasingly diverse nature of our society, the prospect that Caucasians will be a minority in the United States. I think that's creating great social tensions, great political tensions. And I think our challenge is to work our way through that, and to maintain sufficient stability and civility, so that when that eventuality occurs as it will for sure demographically, I wish that our media saw it more as their role to be protectors of civil society rather than agitators.

D. Blumenthal: And I know that different ends of the political spectrum will take different viewpoints on who the major offenders are in that regard. But I think there's no question that we have a media environment right now which is fundamentally different, and may explain to some degree the level of partisanship and the fierceness of the partisanship that we are now experiencing.

R. Pearl: Very well said. You're currently the president of The Commonwealth Fund and engages independent research on health and social policy issues. How do you see The Commonwealth Fund helping to move the nation's healthcare agenda in the best way for both the providers of care and patients?

D. Blumenthal: Well, we believe that facts still matter. We believe there is such a thing as valid information. And we believe that and it is the responsibility of those who develop such information to communicate it effectively to decision makers. It's

not enough to do the research or do the analysis, throw it out into the stratosphere and hope for the best.

D. Blumenthal: So we try to produce the right information, at the right time, in the right way, for the right people. And a lot of our effort is devoted to communication and to placing information in front of people at a time when they are ready to consume it and will find it actionable. The same paper, the same chart, the same table presented at one time will have absolutely no impact; presented at another time, can be decisive in the disposition of an issue. And part of what we try to do is figure out what that timing is, and how to get it into the discussion.

J. Corr: Earlier, you had talked about a regulated out-of-pocket maximum. I read an article, I believe it was last year, about how most Americans couldn't afford $1,000 emergency. What should that out-of-pocket maximum be, and why?

D. Blumenthal: I haven't staffed this out, but I think it should be set as a percent of income. And so I think it should be less than 5% of income, that that's a reasonable burden for people to bear. Not zero, but that is actually our definition at The Commonwealth Fund of under-insurance.

D. Blumenthal: If you're spending more than 5% of your income, other than for premiums, if you're spending more than 5% of your income in the consumption of healthcare services. So that's where I would put it. Off hand, I would put it at... I might put it a little bit higher for people who are more wealthy. So if your income is three, four, five times poverty, maybe it's 10% of income.

J. Corr: A few years ago, New York had proposed sugary soft drink ban. And my question is, what do you think the government's role is in the regulation versus freedom of preventative health? I mean, should the government be able to do things like regulate the size of sodas to do things to essentially force people to be healthier to help drive down costs?

D. Blumenthal: Well, though I understand and respect government, I'm not instinctively for regulation. I actually support the idea of markets where they work. One of the problems we have with our markets when it comes to public health is that information is not a level playing field. The information that promotes the use of foods, and beverages, and chemicals and activities that are dangerous from a health standpoint is huge. There are huge amounts of information available about that aggressive advertising. There's very little counter balancing that advertising.

D. Blumenthal: Because of the nature of our political culture, we don't support aggressive public education around food and other habits. I would like to see much, much more advertising, like anti-cigarette ads, much, much more advertising about the risks of sugared beverages, about the risk of high-sugar foods in general, about the risks of obesity, about the need to wear seat belts, about the risks of vaping, about the risks of medications that are so heavily advertised on

television. So I would like to see a balanced information environment before I jumped to aggressive regulation of foods.

J. Corr: When it comes to that information, what about misinformation? What's the government's role when it comes to things like the anti-vaccine movement and its ability to go far and wide on Twitter and Facebook? I mean, does speech that dangerous go into the realm of yelling fire in a crowded theater, due to the fact that it can essentially cause people to get sickness and die and spread disease?

D. Blumenthal: The case of behaviors that directly jeopardize other people, stand apart from other kinds of behaviors. I think they are appropriately regulated. Requiring that young people get vaccinated before they can go to school, before they can be in public places, I think is very appropriate. I'm less comfortable regulating speech.

D. Blumenthal: I don't think that saying people shouldn't get vaccines is equivalent to shouting fire in a crowded theater. The behavior should be regulated rather than the speech.

J. Corr: With the lobbying power of Big Pharma and other healthcare organizations whose best interest is to keep healthcare as the status quo and as profitable to them as possible, do you think elected and government officials really have voters and patient's best interests in mind?

D. Blumenthal: We need to do something about the financing of our elections. I think that the financing system has become toxic, and I think that it can be traced back to the Supreme Court decision about financing of campaigns, equating financing with speech.

D. Blumenthal: So yes, I think that we are in a period of time when money has too much influence in politics, and that is where it gains its influence, it's in the prospect of re-election. At the same time, we shouldn't forget that many candidates get elected even though they don't have the money that their opponents do. So there are ways, especially the social media world, to reach people without tons of money. But I'm not an expert on campaign finance, I just have general impressions.

R. Pearl: When I was the CEO and in KP, we went from being middle of the pack quality to being number one based upon the NCQA. And I truly believe that the overwhelming majority of the reason had to do with the availability of comprehensive data information through an electronic healthcare system at every point of contact.

R. Pearl: It's why blood pressure was controlled over 90% compared to 65% nationally. Colon screening over 90% compared to 65% nationally. And to me, availability of comprehensive data goes beyond even interoperability. Do you see a way that American healthcare can reach this point where the patient carries the data themselves, whether it's available in some kind of repository that all systems

can enter into and be interactive amongst them? Do you see comprehensive data on the horizon for the American healthcare system anytime in the future? And if so, how are we going to get there?

D. Blumenthal: I do. Right now my biggest hope is associated with the availability of new technologies that enable patients to get access to their personal health information in electronic form. There is recent legislation that passed that requires that all vendors make it possible for patients to get easy access to their data electronically, and that penalize any provider for failing to enable that.

D. Blumenthal: And also there is in the law, encouragement and a new proposed regulation encouragement of third parties. And when you think third parties, think Apple, Google, IBM, Amazon; third parties to step in and provide assistance to individual patients with gaining access to their data, and storing it, and stewarding it. So there may be an opportunity from the grassroots up to create liquid data and pools of data.

D. Blumenthal: Now, I don't consider that anywhere near as effective as what Kaiser has done, or what my home system of Partners HealthCare was doing when I left it. But unfortunately, these large integrated institutions are the exception, not the rule. And so, I think that until providers have the motivation and resources to be leaders and aggressive adopters of intelligent decision supported software and electronic health records, I think we may have to turn to patients to take control.

J. Corr: For patients who are middle to lower income, whose premiums are getting more expensive, deductibles are going up, out-of-pocket costs are rising, and just more and more frustration towards healthcare organizations, their employers and the government. Is there any hope for these people? And if so, when can they expect to potentially see a turnaround or improvement in the American healthcare system?

D. Blumenthal: There's hope if they vote, and they have to vote for candidates who support what they want. And if they are unhappy enough with their current insurance and with their current healthcare system, they will vote for people who will change that. But unless they vote that way, I don't see much hope. So this is something where the electorate carries the responsibility in my view.

D. Blumenthal: We wouldn't have Medicare if it weren't for the massive landslide victory of Lyndon Johnson in 1964. We wouldn't have the Affordable Care Act if it weren't for the massive victory of Barack Obama and his ability to carry both houses of the Congress. Every time we have extended protection to Americans against the cost of illness, it has been because of an election. I think Americans have to care enough about this issue. It's the old, “We've seen the enemy, and it's us,” kind of issue. It's a test of democracy. Of course there are special interests. There are stakeholders. They will fiercely defend their interests, but they don't control elections. They influence them, but don't control them.

R. Pearl: Well, David, your breadth of experience is remarkable. I'm sure our listeners have learned a lot from it. You balanced perspective brings in all points of view. I want to encourage listeners to go to The Commonwealth Fund website to be able to access the information.

R. Pearl: You'll find there quite a number of pieces written by David and by his colleagues, white papers available; the most comprehensive, objective information you're likely to find. And I want to encourage all the listeners to be active forces in trying to make the healthcare not only you receive but all Americans or receive being better. As we're fond of saying on Fixing Healthcare, “Let's make American healthcare, once again, the best in the world.”

R. Pearl: David, thank you so much for participating today.

D. Blumenthal: My pleasure, Robbie. Thanks very much.

R. Pearl: Thank you again, David. Before we go, let's take a few minutes to hear some of the many suggestions from our listeners. The new Fixing Healthcare survey contains two questions. The first one asks listeners to rank the ideas they heard on Season 2. The second question asks, “How can the US government best improve healthcare?” We want to hear your thoughts on both of these survey questions. You can vote and add your ideas at robertpearlmd.com.

J. Corr: Many of our listeners pointed to the lack of price transparency when it comes to their medical care. Matt Long said that change will come through, quote, price transparency and hospital competition, just like all other private industries. Daniel Riney wrote that customers have the right to know what they will pay for service prior to receiving that service. He says that healthcare is one of the only remaining industries where consumers are left in the dark until the services are already rendered.

J. Corr: Robbie, you're a strong proponent of greater pricing and cost transparency in healthcare, especially when it comes to our nation's hospitals and drug companies. What do you think about our listeners' suggestions?

R. Pearl: Like Matt and Daniel, I believe that transparency is a first step. Hospital costs remain the most expensive part of the bloated American healthcare system. In a Forbes article I wrote on the subject, titled, 3 Ways to Stop Hospitals from Overcharging Patients. I recommended, one, unmasking the chargemaster, two, capping out-of-network fees, and three, simplifying billing by forcing hospitals to bundle their fees.

R. Pearl: The combination of all three, if done well, would allow patients to know what it will cost to deliver a baby, or have a total joint replaced in the future, offering greater competition between hospitals, and hopefully lower prices for patients and their families.

J. Corr: Once again, thanks to Matt Long, Daniel Riney, and everyone who has participated in the new Fixing Healthcare survey so far on robertpearlmd.com.

R. Pearl: Please subscribe to Fixing Healthcare on iTunes or other podcast software. If you liked the show, please rate it five stars and leave a review. Visit our website at fixinghealthcarepodcast.com. Follow us on LinkedIn, Facebook, and Twitter @FixingHCPodcast. We hope you enjoyed this podcast and will tell your friends and colleagues about it. Together, we can make American healthcare, once again, the best in the world.

J. Corr: Thank you for listening to Fixing Healthcare with Dr. Robert Pearl and Jeremy Corr. Have a great day.