

September 29, 2017

Ray Padgett | raypadgett@shorefire.com

Mark Satlof | msatlof@shorefire.com

T: 718.522.7171

Intelligence Squared U.S.

## The U.S. Health Care System Is Terminally Broken

For the Motion: Shannon Brownlee, Dr. Robert Pearl  
Against the Motion: Dr. Ezekiel Emanuel, Dr. David Feinberg  
Moderator: John Donovan

AUDIENCE RESULTS	
Before the debate:	After the debate:
42% FOR	45% FOR
34% AGAINST	51% AGAINST
24% UNDECIDED	04% UNDECIDED

Start Time: (00:00:00)

[applause]

John Donovan:

Gone are the days when it was part of the rhetorical repertoire of many American politicians to proclaim that US healthcare is the best in the world. Whether that was ever true or not this proud and optimistic statement did take on the gloss of a truism. But it's not something that many people are saying anymore. Although they are saying that there are ways that the system can become the best.

But first we have to get to the bottom of what's gone wrong and to figure out just how busted the system is. Is there anything salvageable to build on or is it so broken that we need to erase what's there and start over with a clean slate? Well, that sounds like the makings of a debate so let's have it. Yes or no to this statement: the US healthcare system is terminally broken. A debate from Intelligence Squared US. I'm John Donovan. We are in Rochester, Minnesota, in partnership with the Mayo Clinic Center for Innovation and its Transform conference.

00:01:01

As always our debate will go in three rounds and then the audience here in Rochester will vote to choose the winner. And only one side wins. What we'd like to do now is have you go to your phones and vote to tell us where you stand on this motion before you've heard any of the arguments. After you've heard all of the arguments, at the end of the debate we have you vote a second time. And this time what we do is compare the difference between the first and the second votes. And the winner of our debates is the team whose numbers have moved up the most in percentage point terms between the first and the second vote. Our motion is the US healthcare system is terminally broken. Let's meet our debaters.

First the team arguing for the motion. Please welcome Shannon Brownlee:

Shannon Brownlee:

Thank you.

[applause]

John Donovan:

And Shannon, you are senior vice president of the Lown Institute and a visiting scientist at the Harvard T.H. Chan School of Public Health. You are co-founder of the Right Care Alliance. That's a network of activist patients, clinicians, and community leaders. My question to you is how important is it to have grassroots support in healthcare reform?

00:02:07

Shannon Brownlee:

It's absolutely essential. The system isn't going to change itself from inside. And it's going to need outside pressure. And that should be communities. It should be activist physicians. It should be patients. It should be everybody who's involved in healthcare. And that's everybody.

John Donovan:

Okay. Sounds like a little bit of a look ahead at your argument tonight. Thank you for that. And please tell us who your partner is.

Shannon Brownlee:

Oh, my partner is my friend and esteemed colleague Robby Pearl, an author a great book, "Mistreated".

John Donovan:

Ladies and gentlemen, Robert Pearl. Please welcome Robert Pearl.

[applause]

I was just pointed out, the full title of your book "Mistreated: Why We Think We're Getting Good Healthcare — And Why We're Usually Wrong". You're a doctor, Robert, who also has been hugely successful running a major corporation. So tell us, is there anything about getting a medical education, anything at all, that you can then apply to running a business?

00:03:00

Robert Pearl:

There is so much. It's the scientific method of analysis. It's the importance of innovation. It's the mission driven foundation for everything that's successful. It's why I teach at both the Stanford graduate school of business and medical school.

John Donovan:

And you've also proved a success at it. Thanks very much and to the team again let's welcome one more time the team arguing for the motion.

[applause]

And that motion, to remind you, the US healthcare system is terminally broken. We have two debaters arguing against it. Please first welcome Ezekiel Emanuel.

[applause]

Zeke, I want to point out that you're -- you've come out with a new book. It's called "Prescription for the Future: The Twelve Transformational Practices of Highly Effective Medical Organizations." It was our staff's discovery of that book that actually led to this debate. It inspired us to give some deep thought to how we could structure a debate, and we reached out to you. You were very collaborative in helping us think it through and find dividing lines, so we want to thank you for that, first of all.

Ezekiel Emanuel:

Thank you.

00:04:00

John Donovan:

This is your second time with Intelligence Squared U.S. It's great to have you back. And you got huge attention back in 2014 when you declared back then that, as far you're concerned, the age of 75 is a perfectly adequate lifespan and that you would take no extraordinary efforts to live beyond that age. But you've also said that you expect American healthcare to improve substantially by the year 2030, which is 13 years from now. So does that change your mind about this dying at thing?

Ezekiel Emanuel:

No. I'm living a very full and fulfilling life, and I haven't had my first grandchild, but I haven't changed my mind one iota.

John Donovan:

Because you always stick by your guns.

Ezekiel Emanuel:

No, not a foolish consistency. Seventy-five is still a full life.

John Donovan:

All right. Thank you, Zeke Emanuel. And please tell us who your partner is.

Ezekiel Emanuel:

Oh, David Feinberg. He's CEO of Geisinger healthcare and one of the more brilliant leaders in American healthcare today.

John Donovan:

David Feinberg, welcome to Intelligence Squared.

00:05:02

David Feinberg:

Thank you.

John Donovan:

And let's give you a round of applause to welcome you here.

[applause]

David Feinberg:

Thank you.

John Donovan:

And, David, as Zeke pointed out, your CEO of Geisinger -- and under your leadership, Geisinger launched a remarkable innovation: offering patients their money back if they were not satisfied with the kindness and compassion that they expected to receive. Did that move not bankrupt Geisinger?

David Feinberg:

Oh, just the opposite, John. I think it's been the best secret shopper program ever in healthcare. Our patients are telling us what's right and what's wrong.

John Donovan:

That's excellent news. And again, I want to thank -- welcome the team arguing against this motion: The U.S. healthcare system is terminally broken.

[applause]

We go in three rounds. Let's move on to round one. Those are opening statements from each debater in turn. They will be six minutes each. And, Shannon, you can make your way down the stage. Up speaking first in support of the motion the U.S. healthcare system is terminally broken, here is Shannon Brownlee: -- here is Shannon Brownlee: senior vice president of the Lown Institute. Ladies and gentlemen, Shannon Brownlee:.

00:06:05

[applause]

Shannon Brownlee:

I think this is my one opportunity to feel like a model, is walking down that runway. [laughter] So you're going to vote on a single premise, but in fact there are two ideas in that premise, and one of them is you have to ask yourself the question just how broken is the system anyway. And my partner Robby Pearl and I agree that it is incredibly broken. If it were a patient, if the healthcare system were a patient, we would have put it in the ICU long ago. But the second thing you must decide is whether or not the reforms that are in place can revive that patient. And we agree again, Robby and I, it can't. They can't. It is in worse shape than our opponents are going to argue, and we think the reforms are less than adequate. So my job is to paint a picture of the system that is, and Robby will lay out a great system that could be, and what it will take to get there.

00:07:07

Now I warn you the picture I'm going to paint isn't very pretty, and some of you, especially those of you who work in organized salaried group practices like Mayo, like Kaiser, like Geisinger, may think I'm exaggerating. But you are islands of excellence in a sea of mediocrity, and out there it's a bit of a warzone. We have fragmented care. We have burned out physicians and nurses. We have three -- a quarter of a million patients die every year of errors, nosocomial infection, and adverse drug events. We've had a record number of drug recalls in the last decade, in part because we have an FDA that is a captive agency. It's bought and paid for by the industry that it's supposed to be regulating. We have -- and don't get me started on medical devices. We have tragic care for the elderly. We've almost killed primary care. And we're still paying fee-for-service even though we know that fee-for-service rewards more care, not better care.

00:08:09

It's kind of like paying for a car based on the number of parts in the car. And we still do not have universal coverage. Meanwhile costs are out of control. They're out of control because prices are out of control. And it's not just drug companies that are the problem. It's that everybody is charging what the market will bear. Costs are also out of control because of how much we waste on fraud, on administration, on inefficiency, and on my special interest overtreatment. We spend about \$300 billion a year on services that patients don't need. And when you add it all up the waste is about \$1 trillion, \$1 trillion. So costs are also out of control because we have massively overinvested in the hospital sector and underinvested in primary care and community based care.

00:09:03

It's because -- and hospitals are now consolidating as fast as they can in order to capture market share and drive up prices even higher. They are investing in technology and specialty care, not because that's good for the community, because it's good for their bottom line. So I'll give you an example. I live in Washington, D.C., and two hospitals have proton beam machines and two more are building them. Now this is a \$100 million machine that has been shown to be effective -- more effective than standard radiation therapy for a handful of cancers. At most we need one proton beam machine in Washington. In fact really we don't need any because we've got two in Baltimore which is 30 miles away.

So hospitals are saying to heck with the evidence. If it's good for the bottom line we're going to invest. As long as we keep paying free-for-service, hospitals are going to be thinking more about margin than they are about mission. Now are ACOs going to right-size our hospital sector?

00:10:08

So in 2012 we had 32 pioneer ACOs. Today we have eight. The other 24 dropped out because they didn't like the risk. And you can't blame them. When most of your book of business is in fee-for-service and a small part of it as risk it's like having one foot in two different canoes.

So every one of these problems is fixable. But they should be seen not as isolated ailments. They're kind of -- they're a kind of sepsis. They're systemic failures requiring systemic solutions. But the majority of actors out there, what Robby calls the legacy players, the hospitals, the drug companies, the AAMC, the device makers, the insurers, they aren't going to like systemic solutions very much. And they are resisting a lot of these solutions. And they won't fix the problems that exist until they have to.

00:11:06

So hospitals bundle payments. They're not going to change hospital costs appreciably. They're going to -- they're going to be an incentive to deliver more bundles. And then there's Medicare

for all. Now I hate saying this as a card-carrying Bernie supporter and a supporter of single payer. But if we do Medicare for all that just pays fee-for-service or worse pays fee for service and has Medicare fees go up to what private pay we're in trouble.

Now our opponents are going to give you examples of incredible care, fantastic primary care, fantastic -- fantastic medical records. Many many wonderful innovations. But the problem is these are million dollar solutions to a trillion dollar problem. And they are not going to scale up. They are one-offs. So given this I think that you have to vote in favor of the premise. The American healthcare system is terminally broken. Thank you.

00:12:07

John Donvan:

Thank you, Shannon Brownlee:.

[applause]

And that's the motion. The US healthcare system is terminally broken. Our next debater will be speaking against the motion. He is Zeke Emanuel, vice provost for global initiatives at the University of Pennsylvania and author of "Prescription for the Future". Ladies and gentlemen, please welcome Zeke Emanuel.

[applause]

Ezekiel Emanuel:

Everyone agrees that the US healthcare system is broken. There's \$800 billion, \$1 trillion of waste, at least \$200 billion of unnecessary care, and \$130 billion of inefficiently delivered care. The quality of the American healthcare system is not great almost no matter how you measure it, whether it's infant mortality, survival for acute myocardial infarctions. Even cancer treatments that we pound our chest on as being the best in the world. Childhood leukemia we're exceeded by Germany by four percentage points.

00:13:06

Breast cancer France does better than us. We are generally underperforming. No doubt about it. But the key word in the proposition is terminally broken. Are we terminally broken? Are we beyond fixing? Now let me just say, Dr. Pearl there is a reconstructive surgeon. My partner, David Feinberg, is a child psychiatrist. I'm the only one who's an expert in terminal. I'm an oncologist. And I will tell you, we are not terminally ill. Sick, but not terminally ill. If you go around the country, there are multiple points of light, much more than Shannon says, and not only reserved for places like Mayo Clinic, Geisinger, and Kaiser. There are many, many places. You go to Care More, which is a Medicare Advantage plan in South California, and has now branched out into Medicaid and other programs around the country in places like Tennessee

and Iowa, they care for chronically ill elders, much sicker than the average Medicare patient, and they do phenomenally well.

00:14:10

They have 45 percent fewer hospital admissions than Medicare -- regular Medicare. Their readmission rate is, if you control for risk, 10 percent compared to Medicare's average at 17 percent, and in their dialysis patients they have 85 percent fewer bed days. Just one example. If you go to a small group in Hawaii, they've addressed behavioral health problems by co-locating a lot of psychologists in their offices. This is a 15-person primary care group with a couple of surgeons and a couple ob-gyn doctors. For four days a week, they co-locate psychologists in their practice, and they treat depression, anxiety, smoking cessation problems, insomnia, and even patients who are noncompliant with medical disorders, and have substantially improved their performance. Palliative care, another area where we have underperformed for many years. I've been studying it for 35 years.

00:15:08

We now have interesting groups. A company -- for-profit company based in Nashville, Tennessee, Aspire, that begins palliative care not in the last month or the last two weeks of life, but 12 months before they identify patients, send out a nurse to the home. And they've seen 25percent savings and keeping patients in their homes over that period of time. Hoag Orthopedic Institute, again, in Southern California, they have done performance measurement and transparency correct. They have looked at all their data. They've done time motion studies and got out every bit of inefficiency in their system. They flip ORs in 22 minutes. They have dropped their surgical site infection almost to the zero level. They publish all their results on outcomes, on the web, including patient-reported outcomes of pain relief and getting back to activity, and they offer people -- not just in Medicare but everywhere -- a fixed payment for their service, and they publish it right on the web and you can get it for that price.

00:16:19

These are but a handful of thousands of examples around the country. So how do we scale them? Well, let's be honest. The key is behavior change -- behavior change of doctors and behavior change of patients. How are we going to get doctors and hospitals, skilled nursing facilities, home healthcare agencies and all the rest to change? We know. We have to change the financial and nonfinancial incentives. There is no disagreement between our side and the affirmative side, that we need to change off the fee-for-service system. The fee-for-service system rewards doctors for doing too much. I'm an oncologist. It rewards us for giving chemotherapy.

00:17:06

The question is, can we move off the fee-for-service system. We already are moving off the fee-for-service system. Shannon downplayed the accountable care organizations. Actually, today there are 32 million Americans in ACOs through Medicare and commercial plans, and we know that the longer a group stays in the ACOs, until the fourth year, then they begin to see real transformation. Bundled payments. We've seen tremendous change in bundled payments, in creating efficiency, in bringing down the cost, and actually bringing down -- making quality the same. We don't sacrifice at all. We have Medicare bundles, we have private insurance bundles, and we have states like Arkansas and Tennessee introducing bundles broadly. They are going to expand because they actually bring returns relatively quickly. And most importantly, we have MACRA, which is a bill passed by -- a bipartisan bill passed, and it is financially incentivizing doctors.

00:18:06

Either they take these alternative payment methods, which moves them off fee-for-service, or they have very, very high pay for performance up nine percent or down nine percent to actually improve quality, but also being responsible for the cost of care. Yes, we can transform the American system. It's not terminally ill. But we need to be careful about the timeline. We are not going to transform it overnight. It takes four years before you begin to see change and then ten years before change sets in. 2030 is the right timescale. This is not like flipping the switch. This is change over time of a \$3.4 trillion industry. We are not terminally ill. We can save the American healthcare system.

John Donovan:

Thank you, Zeke Emanuel.

[applause]

And a reminder of what's going on. We are halfway through the opening round of this Intelligence Squared US debate. I'm John Donovan. We have four debaters, two teams of two fighting it out over this motion: The US healthcare system is terminally broken.

00:19:05

You have heard the first two opening statements and now on to the third. I want to welcome to the stage Robert Pearl, former CEO of the Permanente Medical Group and author of the bestselling book "Mistreated: Why We Think We're Getting Good Healthcare — And Why We're Usually Wrong". Ladies and gentlemen, Robert Pearl.

[applause]

Robert Pearl:

The American healthcare system is terminally broken. Shannon's told you the magnitude of the problems. And the solutions that exist are simply inadequate. I think of them as a patient with

systemic infection from bacteria. Give it a couple of penicillin pills not powerful intravenous antibiotics.

The reason is simple. What's in place today is a compromise, a political compromise to get the Congressional votes and to avoid the ire of the hospital systems, the health plan systems, and the drug industry. It is simply inadequate to be able to overcome the shortcomings -- shortcomings that led to the premature death of my father.

00:20:08

My father Jack Pearl was an amazing man. The son of two immigrant parents he worked his way through college and dental school. When World War II came around he could have stayed behind American lines. He volunteered for the 101st Airborne. Parachuted on D-day. He and his unit were captured by the Germans. He led a daring escape at night. Brokaw would call them the greatest generation.

Later in life he developed a hemolytic anemia. He needed to have his spleen taken out. The operation went well. My brother and I -- my brother's the chairman of anesthesia at Stanford -- handpicked the doctors, the half in New York and the half in Florida where he lived for each six months of the year. They were excellent physicians. They all knew that after a splenectomy you're at much higher risk -- much higher risk for infection called pneumococcus. They all knew that there was a vaccine that could have prevented the complications.

00:21:04

But the ones in New York thought Florida gave it to him. Florida thought New York. Primary care though specialty care. Specialty -- he never had it.

He came out to visit my brother and me. Dinner at my house, with my brother's house in Palo Alto. Next morning at 5:00 my brother finds my dad on the floor unresponsive. Four days in the ICU. Three weeks in the hospital. He survives the admission but never the complications. The diagnosis? Pneumococcal septicemia. One of 200,000 people that year and every year including this year who will die from preventable medical errors.

Embedded in a story is much that is wrong -- much that is wrong with American medicine today. It is still paid. Ninety-two percent of physicians get paid on a fee for-service-basis. They get rewarded for a splenectomy. They don't get rewarded for thinking about how they can make sure he got the vaccine that is needed. If we're going to address not just quality but also address cost we have to move from fee for service to capitation. It's difficult but anything less will be incomplete.

00:22:12

Zeke talked about bundled payments. The evidence says in bundle payments costs come down on a unit basis but doctors do more. When hospitals and doctors consolidate what do we see happening? They don't use it to improve efficiency and effectiveness of care. No. They use it to raise the price by controlling the marketplace. And the alphabet soup of current Medicare, MACRA and MIPS and APMs, doctors don't even understand this. Yeah, they'll meet the bundle -- the requirements to get paid but they will never change the way they provide care under the current rules.

His doctors didn't have the information they needed. Every American needs to have the totality of the medical information available to every physician, hospital at every point of contact. It can be done. It's called ATMs. But it won't get done. Why is that? Because the people who manufacture and sell the electronic health records are not going to open up what's called APIs, the application processing software that's necessary for third party developers to come in, because they know it will break the stranglehold they have on those who have purchased the systems already.

00:23:18

And we need to make sure we address the issue of drug prices. Drug costs are rising three times more rapidly than medical inflation, five times more rapidly than overall inflation. It used to be that drug companies spent all their money on R&D. That's not happening anymore. A lot of them are simply acquiring competitors, creating monopolistic control of that marketplace. And as a consequence of doing that, they're able to simply raise price. Just look at all the things that happened with EpiPen. And primary care. My father's primary care physician was overwhelmed, as physicians are across the nation today in primary care. Twenty, 25, 30 patients being seen every single day.

00:24:12

We talk about primary care, but we still train more specialists than primary care physicians. The 15-minute has got to become a thing of the past. The changes that are happening, the Medicare changes are making the life of primary care worse. I asked a friend the other day, I said how come there are 80 separate measures to evaluate primary care performance. He said because that's all the columns that exist on an Excel spreadsheet. There would be twice as many as they could have as many in place. The government needs to intervene in the drug world. They need to increase competition. The government needs to intervene and use Medicare to buy drugs on behalf of patients. Every other nation in the world does it. Our Congress has prohibited our government from accomplishing it.

00:25:10

What we know today is that the American healthcare system is terminally broken. All the small fixes you heard about from Zeke will make a small degree. But one-offs, people in one area will

do it, but not another area. We've got to change all of American medicine, how it's organized, how it's reimbursed, how it is led, how it's technologically supported. It is terminally ill. It does not have to be. I urge you to vote yes on the motion so that work can begin. Thank you very much.

[applause]

John Donovan:

Thank you, Robert Pearl. Again, the motion is the U.S. healthcare system is terminally broken. And here is our final debater in making opening statement against the motion, David Feinberg, the president and CEO of Geisinger. Please welcome David Feinberg.

David Feinberg:

Thanks, John.

00:26:06

[applause]

So this -- I'm not a professional debater, so this may be suicide, but I'm going to start with disagreeing with Zeke, okay?

So Zeke is an expert on terminal illness. But, hey, I'm a psychiatrist. I'm the expert on behavioral change. So let's talk about behavioral change. We could fix every problem we have in healthcare immediately -- 50 percent of the cost -- if we ate right, we didn't use illegal drugs, we drank alcohol in moderation, we wore our seatbelts, we didn't shoot one another, and we prevented adverse childhood situations that we know we can prevent. Overnight, we fix the healthcare debate.

[applause]

And all we hear about -- ACOs and MIPS and MACRA -- that's mumbo jumbo. And when -- I'm sure that our opponents will tell you that the United States spends more on healthcare than most industrialized countries, and our outcomes aren't as good.

00:27:11

But that graph is actually misleading, because the United States spends the least amount on social services compared to those other countries. And when you combine social service spend and medical spend, we're kind of just in the middle. So we have an option. We can either start spending as a country on social services, or it's up to the healthcare system to fill that gap. So can it be done? Well, I would ask all of you in this audience -- I mean, if you look at the graphs that they will talk about, if you have crushing chest pain right now, and that graph shows that it's better for you to get care in Uruguay, are you not going to go across the street to the Mayo

Clinic? So acute care in America is actually excellent. We've designed our system to do that. And I take really offense by what Robert says, because Robert represented an organization that has showed our country how to do this the right way.

00:28:10

Kaiser Permanente, which starts in Oakland, California, Geisinger Health System, which starts in Danville, Pennsylvania, are examples that health care reform does not start in Washington, D.C. It starts in communities that are committed to the people that are living there, that understand the problems, and engage in creative, innovative solutions to make things better, so that every patient gets care that's compassionate, safe, dignified, and low cost. So we've done some things at Geisinger. We've sequenced 100,000 people's entire DNA for free. We look at their DNA, and about 4 percent of those people have medically actionable conditions that we could intervene with before the bad thing happens. And on those cases, there's probably about four first degree and second degree relatives that are also affected. So that's genetic code. It's health care is not just about getting to the doctor and getting to the hospital. It's understanding your genetic code and also your zip code.

00:29:18

And what we looked at zip codes where we provide care, we have towns like Shamokin, Pennsylvania, where 80 percent of the kids are on subsidized lunch. The rates of diabetes are 1 in 4 to 1 in 5. Food insecure people with great health care through Geisinger still have measures of blood sugar that are out of control. Guess what happens when we bring those people in and we say to them, "Here is food, fresh fruits, vegetables, lean meats, legumes. And if you're living in a motel, we've got spatulas for you, and we have microwaves and hot plates. We're going to teach you about your diabetes, and you're going to give you and your food -- you and your family this food to eat.

00:30:01

Every single patient has had a decrease in their hemoglobin A1C, in their blood pressure, in their weight. If this was a pill, it would be a multibillion dollar pill. We can use food as medicine. And it's a hundred percent -- if a pill decreases your hemoglobin A1C by one point, it gets approved. We've seen patients have decreased in hemoglobin A1C of four or five points to the normal range. I think together communities can say, we're going to eliminate Type II diabetes. And Kaiser has been a star at this. They've been a star at making sure that every patient that comes in -- when you go to the dermatologist at Kaiser and you check in, they say to you, "Mr. Feinberg, we notice you haven't had your colonoscopy. Can we get that scheduled for you?" They're closing care gaps on every single patient so these primary preventions are saving millions of lives. And they've published. Now, the question that Shannon says, are these just pilots, and can they scale? I got news for you.

00:31:09

People call us, people call Kaiser every day. About 10 or 12 years ago, we did the first heart surgery with a warranty. The New York Times said if you had a -- the New York Times called it a warranty. If you had an infection or got readmitted, we didn't charge you extra money. Hey, guess what? Bundles -- and we can debate whether they're good or bad -- have now spread across the country. So I believe health care reform begins with the docs, the nurses, the patients, the moms, the brothers and sisters, the communities coming together, taking care of one another, scaling these great ideas and making sure that every patient gets the exact kind of care that you'd want for everyone in your family. Thank you very much.

[applause]

John Donvan:

Thank you, David Feinberg. And that concludes round one of this Intelligence Squared U.S. debate where the motion is "The U.S. health care system is terminally broken."

00:32:05

So, in round two, the debaters direct questions to one another and take questions from me. We have two teams arguing for and against the motion the U.S. healthcare system is terminally broken. We've heard from Shannon Brownlee: and Robert Pearl, who are arguing for the motion. They're saying that, yes, there are reforms in place, but they cannot make the system work. The costs are out of control, too much emphasis still on paying fee-for-service. They don't think that the islands of excellence, which both sides concede are out there, can stand up to the overwhelming sea of mediocrity. They don't think that these things are ultimately scalable. They think also the government does need to get involved in some of this. But basically, their position is that metaphorically, the system is so sick right now that it will not yield to a couple of penicillin pills. The team arguing against the most, Zeke Emanuel and David Feinberg, they concede also that in fact the system is broken, but they say it's not terminally broken.

00:33:06

They are pointing to numerous points of light. They've talked about palliative care, various technological advances. They're saying we are sick, but we are not terminally sick. They say there are thousands of examples of things that are working and that these can be scaled given behavioral change on the parts of stakeholders in the system, and they think that those behavioral changes can be brought about. Basically, they are saying that the solutions for the future, which probably both sides agree upon, in the end game they're saying that those solutions for the future are already baked into the present -- a rather radical forecast from Zeke Emanuel that he thinks we're going to be in very decent shape in the year 2030. I want to take the argument to the side arguing for the motion and start with you, Shannon Brownlee: Your opponents taking issue with your argument that the points of light, the islands of excellence cannot be scaled, and they are saying sure they can. Argue that point with them.

00:34:07

Shannon Brownlee:

Well, you know, I've been around a long time and reporting on healthcare for a long time when I was a reporter, back when I was a reporter. And we've seen periods of ferment in healthcare before, and each time there are these incredible points of light, and I don't argue them at all. They are fantastic, and there are a lot of them. But somehow, the existing legacy players somehow manage to beat it back. Why is this time different?

John Donovan:

Zeke Emanuel.

Ezekiel Emanuel:

So I think let's look at the mid-90s, we had a big push to control healthcare costs after the failure of the Clinton healthcare reform, and it was managed care, and it basically was 1-800-justsayno. And the public did revolt against that and did want more choice and not drive-through deliveries. And the consequence was we got rid of any management, and cost did go up. Now we have a different problem.

00:35:04

Now the problem the public is upset about is affordability, it is the inefficiency and unnecessary care of the system, and the public -- the various people who can control the system are responding. We do have very powerful -- I know that they dismiss them -- but they agree that bundled payments are making the system more efficient, and we have to get the per-unit cost down. There are many ways to do that, shared decision --

John Donovan:

But, Zeke, how do you answer her question, why is this time different?

Ezekiel Emanuel:

I'm explaining it. You have the public that is pushing, you have employers that are pushing and you have changes in policy throughout the system.

John Donovan:

Okay, so you're saying --

Ezekiel Emanuel:

Not just -- not just in Medicare, Medicaid, but also in the private sector through employers and through insurers. And that push, altogether, is going to drive the system.

John Donovan:

Okay.

David Feinberg:

And we have something else that we didn't have back then. We have data. We now have an electronic health record, as clunky as it is and tough as it is. We now have data to help make these decisions that we didn't have in the 90's.

00:36:02

John Donovan:

So you're saying there is now an alignment of forces that has never been seen before working in favor of your side of the argument. I want to take that to Robert Pearl. That's why they're saying that this time is different.

Robert Pearl:

Yeah. So a couple of things. First, in terms of bundled payments, what does the data show? Bundled payments work very nicely to lower your price. What have we seen? We've seen two things. Physicians doing more total joints now, and on spine surgeries that are more complex, the cost increase for the complexity that has been put in place in response is more than the dollars that have been saved -- in an article published this month, Zeke -- published this month on the outcomes. But I want to address something that David said, which is, he's absolutely right. We have places like Geisinger and Kaiser and Mayo that do things very well. They've been at it for a hundred years, Mayo -- over a hundred years, 70 years. The question is, how do you take a broken fee-for-service system, a 19th century cottage industry with doctors scattered across the community, small hospitals in every town, and now put that together into a Geisinger or Kaiser? We believe that that's not going to happen without major force.

00:37:01

Dr. Ezekiel Emanuel

Let me cite -- let me cite Kaiser Mid-Atlantic, just to the former CEO of Kaiser Northern California.

He knows this well. Kaiser went into Washington, D.C., Virginia, and Maryland. And like many times before it wasn't going well. And it almost went bankrupt in 2007 and 2008. And then it got a very important leader, instituted the Kaiser practices correctly, and now it's the most popular health system in Washington, D.C. It's keeping costs down, quality up, and its enrollment has gone from -- gone up by 50 percent from about 400,000 a few years ago to 600,000. It's a five star Medicare plan. His case himself shows that you can --

John Donovan:

Okay.

Ezekiel Emanuel:

-- transform the --

John Donovan:  
Zeke, let him respond.

Ezekiel Emanuel:  
-- [unintelligible] far away from home.

Robert Pearl:  
So Zeke --

John Donovan:  
Let him respond.

Robert Pearl:  
So Zeke, I was the CEO who went to Mid Atlantic. I'm the one who led that entire process.

Ezekiel Emanuel:  
You can show it can be done.

Robert Pearl:  
I led it in an environment that was integrated, that was prepaid, that had technology on all of the patients, and brought in with me a huge amount of leaders. It can be done. The problem is it can't be done across the states.

00:38:09

David Feinberg:  
John. John, can I say something?

John Donovan:  
No. Wait. I want Shannon to [unintelligible].

Shannon Brownlee:  
Tell me how --

John Donovan:  
You can --

Shannon Brownlee:  
-- how does Kaiser --

John Donovan:  
Hang on a second.

Shannon Brownlee:  
-- how is Kaiser Geisinger -- Geisinger better? How is Geisinger going to make -- make inroads in Pittsburgh?

David Feinberg:

You know what? Let me read from Robert's book.

Shannon Brownlee:

You're not going to answer the question.

David Feinberg:

Okay. Let me --

John Donovan:

Wait, actually we want to hear questions answered. You can get to that moment.

Shannon Brownlee:

Yeah.

John Donovan:

She asked a good question.

Shannon Brownlee:

How is it --

John Donovan:

And then you can take that moment.

Shannon Brownlee:

-- going to make an inroad in --

David Feinberg:

Actually -- actually Robert is an inspiration for me and he's given the answer to that question.

Shannon Brownlee:

Okay.

David Feinberg:

Here's how -- what he says from his book. Okay. This -- actually Robert should bring his chair over here.

[laughter]

Look at this. Is this you, Robert? So it says transforming the conditions of American medicine will be difficult but possible. And "Mistreated" outlines the steps necessary to transform American medical practice. The first step -- so here's the answer, Shannon, from your partner, will be awakening, becoming aware of patients, how we're mistreated. That's the first step.

00:39:05

From there we will need youthful optimism. We can't make this a terminal illness. We have to fix this. We have a collective confidence that our problems can be solved. That will be followed

by years of hard work. And at the end I hope we will have freed American medicine from the outdated cottage industry --

John Donovan:

Okay.

David Feinberg:

-- it resembles today. Robert -- Robert Pearl 2107.

John Donovan:

Shannon Brownlee: to respond.

[applause]

John Donovan:

Shannon Brownlee: to respond.

Shannon Brownlee:

Yeah. But you've got to read the whole book to find out, David, that it's -

Robert Pearl:

There's a difference between being --

Shannon Brownlee:

-- not going to happen in Pittsburgh.

Robert Pearl:

There's a difference between being terminally ill and dead. We're not saying it's dead.

Shannon Brownlee:

We're not saying it's dead.

Robert Pearl:

We're just saying it's terminally ill and something radically different than just moving along little steps at a time -- things will get far worse --

David Feinberg:

You know, my wife --

Robert Pearl:

-- before they get better.

David Feinberg:

-- is an ICU doctor and when they're terminally ill we've got to go slow. We've got to talk to the family. We've got to listen. If we do something radical in the ICU I think we would all agree that's a mistake.

00:40:07

Ezekiel Emanuel:  
Before 2010, before --

Shannon Brownlee:  
Okay. I think this metaphor --

John Donovan:  
Wait, wait, wait.

Shannon Brownlee:  
-- too far.

John Donovan:  
Shannon.

Shannon Brownlee:  
This metaphor has gone too far. It's time to --

John Donovan:  
Okay.

Shannon Brownlee:  
-- call a moratorium on the patient, the healthcare system as a patient in the ICU.

Ezekiel Emanuel:  
Before 2010 we were all fee for service except for a few holdouts like Kaiser, like Geisinger. We put into the Affordable Care Act a mechanism to have payment transformation which was led by Medicare but not only by Medicare. We've had states adopt payment transformation for their Medicaid programs. I mentioned Arkansas and Tennessee as but two example. Ohio is doing stuff and so are other states. Oregon's doing some interesting things with its Medicare population. In addition we have private payers that have entered this space and are using various different payment mechanisms to shift. I'm working with the Blue Shield firm in Hawaii. They're trying to move all their primary care doctors in the state of Hawaii to capitation. It's not easy and it takes time.

00:41:07

John Donovan:  
Robby.

Ezekiel Emanuel:  
And those changes are happening throughout the country. It is not just a few points of light.

John Donovan:  
Robert.

Ezekiel Emanuel:

It is tens of thousands.

John Donovan:

Robert Pearl. Has Zeke Emanuel effectively refuted your point that it can't be scaled?

Robert Pearl:

I don't think so at all. He's talking about these very small places that can do something.

Ezekiel Emanuel:

Kaiser's an \$80 billion organization.

John Donovan:

Wait, wait, wait, wait.

Robert Pearl:

What physicians --

John Donovan:

Let him finish his point and then we can come back.

Robert Pearl:

Physicians learn it's always easier to do more than to do things more efficiently and better. If you actually follow the thinking through you're going to end up having to close hospitals, have fewer specialists, make massive investments in technology, and just think back to when they tried to close naval yards. The protests that are going to happen are going to be massive. This change is going to be so radical that I think we have to understand the amount of pain that's there. And that's why we see it as being terminally broken. Not impossible, but the likelihood is people will turn around and go back before most of them progress.

00:42:09

Shannon Brownlee:

And by the way, Hawaii is a -- a very, very interesting place because there's really only two insurers. Well, there's Medicare. But there is HMSA, which is the Blue Cross/Blue Shield, and there is Kaiser. And that's -- and it's a -- that actually makes a difference.

Ezekiel Emanuel:

Shannon, that's true of many states. Alabama, the Blue Cross plan has 80 percent of the market. Tennessee, the Blue Cross plan has 80 percent of the market. The fact is, you have big insurers across the country. You have CIGNA and many others that are trying to move to Capitationmove to steering patients to efficient providers. You have the Massachusetts Blue Cross and Blue Shield plan which introduced the AQC, the alternative quality contracts --

Shannon Brownlee:

Which primary care doctors loath.

Ezekiel Emanuel:

Wait a second. Which brought down costs and improved the quality, but it took four years of working hard at it. And it is -- has to be sustained. And if we start out now, and we are doing this, and you're lifting up the pot and saying, after one year, "Is it boiling yet?"

00:43:07

That is too early. Change takes time. It takes four years before you get the maximum change and then 10 years. It is going to be resistant. There's no doubt. But we have data, as David says, driving the system. We have changes in financial -- financial incentives driving the system. And we also do have the closing of hospitals --

John Donovan:

Okay.

Ezekiel Emanuel:

-- and the shifting of incentives.

John Donovan:

Zeke, I have to break in, with respect, because you're very compelling.

Ezekiel Emanuel:

It's okay.

John Donovan:

Just in terms of time. I need to let these guys talk, so I'm going to break in every now and then just so your opponents --

Ezekiel Emanuel:

That's fine.

John Donovan:

-- can talk. But this doesn't mean we don't want to hear what you have to say. But to the other side, can you -- I wanted you to take on --

Shannon Brownlee:

I know. Which point do we respond to? There's so many coming in a streak.

John Donovan:

I'm interested in the argument you were making. Zeke just mentioned resistance.

Shannon Brownlee:

Yes.

John Donovan:

And you both talked in your opening statement about legacy players, the fact that 92 percent of -- your statistic was percent, Robert --

Robert Pearl:  
Fee-for-service –

00:44:02

John Donovan:  
Still fee-for-service, and they like it. They like it.

Robert Pearl:  
They like it a lot, yeah, 78 percent say they don't want to change.

John Donovan:  
And what's the significance of their just saying they don't want to change, because I think your opponents are sort of saying, "Too bad"?

Robert Pearl:  
Well, you can say, "Too bad," but at some particular point, as I say, in a fee-for-service world, what they're going to do is to start to increase divide The problem right now in -- you know, what David and Zeke is talking about is the same thing we're talking about. I think what we're arguing about is the likelihood of it happening.

John Donovan:  
Right, we are.

Robert Pearl:  
And we're basically saying it's not likely to happen because the hospital will find a way to pay fee for service. We say they're moving towards pay for value capitation. We're talking about small pieces. We're not talking about taking entire populations like Geisinger has or Kaiser has or Mayo has, that's able to scale that. We're talking about doctors in small offices trying to manage all of that. You know, even this very radical Medicare payment under MACRA, nine plus nine Midas. First of all, that's only about quality. It's not going to affect the costs very much. And we're still talking about 10 percent.

00:45:07

The overall practice, the idea having a single electronic record, do you know how difficult that's going to be to get every document in the community?

John Donovan:  
Okay.

Robert Pearl:  
So we're saying the scale is so huge --

John Donovan:  
Okay.

Robert Pearl:

-- it's effectively [unintelligible]. And --

John Donovan:

So you've made -- same thing. You've made a bunch of points, let me let your --

David Feinberg:

So -- so --

Shannon Brownlee:

Well, I'd like to make a couple --

John Donovan:

Okay, I'll let Shannon --

Shannon Brownlee:

-- just a couple, and then I want David --

John Donovan:

Sure. Fair enough.

Shannon Brownlee:

Number one, Zeke, I'm not saying that you look after a year and you say, "Oh, not working. It's terminal." That's not true. That's not what we're saying. It's that it is a massive, massive problem. Number two, it does take time. And number three, we have one state that's globally budgeted all of its hospitals. And it's going along pretty well. It's not like they have suddenly become all -- everybody's at risk instantly. They're moving slowly. It's the state of Maryland. But they're getting there. But it took -- it took a big shift in somebody saying, from the top, "We're not going to pay you fee for service anymore. We're not going to pay the same way."

00:46:05

John Donovan:

David Feinberg.

David Feinberg:

So -- and, Robert, you've got to agree with me on this. Doctors that are coming out of training now are not going into private practice. They're joining Kaiser and Geisinger. They're joining -- they -- when we -- when I used to hire doctors 20 years ago, they want to know how much money they made, when they became partner and all that kind of stuff. Now they want to know, can they still go to Haiti, can they be -- is it team based? And, you know, what's the live white -- live-work balance? It's going away fee-for-service. Kaisers of the world are where people -- or large medical groups are where people are going. So to say that this fee-for-service thing is going to kill us, got us where we were. John Donovan:

But 92percent means what?

David Feinberg:

Let me give an example.

John Donovan:

Well, I just want to answer that question because it's hanging out there. You talked about 92 percent of doctors are still working for fee-for-service. You're saying it's going away.

David Feinberg:

It has to go away. No one is going into fee-for-service. It just doesn't make sense. So it's going to take time. There's a lot of doctors who are 40 years old or 50 years old are going to stay in fee-for-service. But the new ones that are coming out, 90 percent are –

00:47:04

John Donovan:

Another point of dispute I'd say is --

Ezekiel Emanuel:

-- Can I give an example of how we have –

John Donovan:

Zeke, hang on one second. I want to -- I want to pick up a point to keep it in play, that Shannon made, while it's still out there, that she said that change is going to have to come from the top. And you made an argument in your opening, David, that the change actually has to come from the bottom.

David Feinberg:

That's right.

John Donovan:

So respond to her point on that then.

David Feinberg:

You know, when I was at UCLA, we diagnosed the first case of AIDS. We did more organ transplants than any hospital in the United States. We invented Herceptin. Those things don't come from Washington, D.C., right? They come -- those innovations happen in our academic medical centers. They happen in place that's try to figure things out differently. And this health care reform thing is going to happen the same way. And it's because communities, people like our audience are going to say, "You know why we have to do it this time? Because we can't afford not to do it. Because if we don't do it, we don't have money for roads, we don't have money for schools." It's a different day. I think we have a moral imperative to get it right. And I think it's going to get pulled by our communities.

00:48:04

Ezekiel Emanuel:

So can I just say something? I think it's synergistic. It's partially from below, with innovative doctors and hospitals. It's partially from above that changes the financial incentive. Let me give you a very good example of where we've had massive change in the system. It's far from perfect. But before the Recovery Act in 2009, there were 9 percent of hospitals had electronic health records. No doctors had electronic health records. We put in incentives to say you had to health -- electronic health records. I'm not saying it's nirvana. I'm not saying it was rightly done. I oppose many of our regulations and thought they should be different. But today, seven years later, every hospital has an electronic health record. All doctors are getting onboard with it. And we are going to see, in the next generation, those APIs are opening up.

Robert Pearl:

The APIs that Epic opened this week.

Ezekiel Emanuel:

Okay.

[Talking simultaneously]

John Donovan:

I need to break in.

Ezekiel Emanuel:

And the second thing I would say -- just let me say it.

John Donovan:

No, no. Let me -- let me stop at that one and let Robert talk and then I'll come back to you.

00:49:03

Robert Pearl:

So two things. First, you're absolutely right. Hospitals have done it. Fewer than 20 percent of physicians' offices can communicate with that machine even though it's next door. And that is going to be the big leak. It's not getting a hospital to be able to do it to meet regulatory. But I want to talk about --

Ezekiel Emanuel:

The whole point is it's not impossible to do that change. And communication between the hospitals is, again, something that is going to be required of them. And that is going to make a big difference.

Robert Pearl:

So between San Jose and San Francisco, Silicon Valley where I live, there's 10 hospitals doing heart surgery. Three of them do fewer than 300 cases a year. That means that 65 days a year,

they're not doing anything. Guess what they do? They're raising their prices to be able to pay for the inefficiency that's in place. I've seen no change. I've not heard a single CEO talking about closing their thing or putting their systems together. You're going to have to take them and make sure it happens. And that's going to require far more.

David Feinberg:

Robert, where is the most complicated -- who does the biggest volume of complicated surgeries in Southern California?

Robert Pearl:

Probably in Kaiser Permanente or in --

David Feinberg:

Kaiser Permanente, not UCLA, not Cedars.

00:50:02

Robert Pearl:

I understand.

David Feinberg:

So you're saying -- in a market, people are driving by nine or 10 hospitals, through traffic to go to Kaiser Permanente.

Robert Pearl:

But they have no choice right now, David, because they bought the insurance that forces them to go there.

David Feinberg:

They have great outcomes.

Robert Pearl:

And that's the point that I'm saying.

David Feinberg:

What do you mean, "No choice"? It's fantastic.

Robert Pearl:

It happened. If you're going to make it happen, and you want to make it painless, want to make small baby steps, want to have demonstrations, but it sounds great, and nothing's going to change around the cost or around the hundreds of thousands of lives they're losing every year.

Ezekiel Emanuel:

No, look. Here's another good example of where you see change and you see change in exactly the kinds of areas that Robbie is mentioning. CALPERS, the California Public Employee Retirement plan, has gone to reference pricing for a lot of surgical services. They say, "We're going to give you X amount of money. You can go to the most expensive person doing that procedure. You have to pay the difference between the 24,000 we're giving you and the 45,000 they're charging." What happens when you put reference pricing in? Those people charging 45,000 reduce their price because people aren't going to pay that delta.

00:51:09

Robert Pearl:

One operation, Zeke, one operation they're doing for total joints –

Ezekiel Emanuel:

No, they're doing it for card -- they're doing it for cataracts, and they're going to spread it. These are cases that were spreading around the country.

John Donovan:

I want to hear --

Ezekiel Emanuel:

You keep saying -- you keep saying, "Oh, everything's an exception." Everything can't be an exception. These are good examples that are going to be generalized. And that's why you are optimistic in your book--

John Donovan:

All right. I want to -- I want to -- excuse me.

[Talking simultaneously]

John Donovan:

Excuse me. I want to hear more from Shannon.

Shannon Brownlee:

You know, I actually -- I find myself agreeing with a great deal of what our opponents say. I think --

Ezekiel Emanuel:

You want to come over to our side too? Should we do the voting now?

Shannon Brownlee:

Not at the moment. But the piece that's really important that you just said, Zeke, which is that the innovation is bubble -- has to bubble up from underneath. But there are some things that have to be imposed from above. And the shift in payment has to be imposed.

David Feinberg:  
We agree.

00:52:00

Shannon Brownlee:  
So who's going to do the imposing? Medicare hasn't done it yet. I'm hoping at some point it's going to move to some kind of global budgeting for hospitals, and that it's going to start giving - it's going to start putting physicians at risk. But are the private plans really going to move this direction? Are they going to do it? And are they going to do it in a way –

David Feinberg:  
You know, Shannon, I've had an opportunity to work in an academic medical center and now in an integrated delivery health system. It's a culture and an understanding that takes years to develop. And to do it immediately, to turn the switch, would be a disaster.

Shannon Brownlee:  
I know.

David Feinberg:  
So you've got to start it with upside risk only, and then upside and downside risk, and then greater -- I mean, it's an iterative process to get us there. And if we push it, I think we're really - it's a recipe for disaster.

John Donovan:  
So -- wait, wait, let Shannon response, please.

Shannon Brownlee:  
Maybe we should see and look -- look and see what happens in the state of Maryland.

John Donovan:  
Everybody stop for one second. One second. Thanks. I want to remind you that we are in the question-and-answer section of this Intelligence Squared U.S. debate. I'm John Donovan, your moderator. We have four debaters, two teams of two debating this motion: the U.S. healthcare system is terminally broken. In a moment, I want to start going to audience questions.

00:53:09

There's a microphone up here. Just line up. Think in terms of a question that will keep us moving on this topic. Make sure it's short and tight in the question. I don't mind if you state a little bit of a premise before your question, but I really want you to [unintelligible] question. Who wanted to speak on this?

Ezekiel Emanuel:

So we have examples across the board. We have private payers, insurance companies driving some of this, whether it's the Blue Cross and Blue Shield plan in Hawaii, it's Cigna, it's Oscar in New York, which is working towards this in its new markets in L.A. and Texas. We have public plans working towards financial payment change to drive this transformation and care to lower cost and higher quality. We have the various Medicare plans. Plus, we have now a third of Medicare patients are on Medicare advantage, all of whom who have a financial incentive because they are capitated. And then we have Medicaid plans which are also driving towards this. This is -- we're not at the final tipping point, but we are driving to that tipping point, and doctors are responding.

00:54:08

Let me give you one example. When the oncology bundle was announced by Medicare, it was a voluntary bundle to give doctors a set price for giving chemotherapy to patients, and they got more money to talk to patients and less money for their chemotherapy. Fifteen percent of American oncologists voluntarily signed up for this because they want to shift how they're practicing right out of the box. So we have a lot of doctor interest, we have payment change from the various payers. This is the mix for self-reinforcing move towards payment change that's going to lead us to adopting these transformational practices -- which by the way, everyone on this panel, their side and our side, agree are out there. We know how to do this. This is not reinventing the wheel or getting to the moon.

John Donovan:

Okay.

Ezekiel Emanuel:

This is putting in place, spreading what we know.

John Donovan:

Robert -- Robert Pearl to respond.

00:55:02

Robert Pearl:

So, two things. First, Zeke, the oncology change was going to be mandatory, and Congress backed away because of the resistance coming out of the national society. But I want to say the following. This is like the Game of Thrones. This is like the white --

Ezekiel Emanuel:

I don't watch TV. It's not a good analogy.

Robert Pearl:

I'll tell you about the white walkers.

John Donovan:

How do you know it's not a good analogy?

Robert Pearl:

I don't know nothing about the Game of Thrones?

John Donovan:

No, maybe it's a good analogy. We'll find out.

Robert Pearl:

In the first season, everyone talks, well, maybe it exists, it's happening, we're going to fight it, it's going to be there, and then finally by season seven Daenerys' dragons comes and blows down the wall of ice and snow. That's what we're talking about right now. Is this going to happen because people are going to do these very small things? You don't think they're small, except when you actually look at the examples you're giving, that's changing a few things here and there, the totality of American healthcare is not changing significantly enough. And right now the legislation -- I'm going to mention in my closing comments -- the drug industry spent \$150 billion -- I'm sorry, \$100 million the first six months of this year on lobbying and on giving contributions to people's campaign funds.

00:56:07

Do you think they're going to let a significant change happen without a major revolution in this country? The revolution has got to come. It's not going to happen on its own.

[applause]

John Donovan:

Question, sir. And if you wouldn't mind telling us your name --

Ezekiel Emanuel:

By the way, we don't disagree about the revolution has to be propelled by people leading it. We just think there will be a revolution.

Robert Pearl:

I think we're in the revolution.

John Donovan:

Sir.

Male Speaker:

Dr. Feinberg, I'd like to bring you back to your opening statement. As an example, I got off of a train in the Netherlands, and there were bike racks.

David Feinberg:  
Yes.

Male Speaker:

Not for five bike, not for 10 bikes, but for 3,000 bikes. We've pulled physical education out of our elementary schools. We've cut back on sports in our high schools. We've even pulled marching band. And we're taking that away from our society. So I want to come back to your original comments and have you comment further on what society can do. Is it our healthcare system that's broken or are there other contributing factors that cause the United States to be lower in the overall ratings?

00:57:12

David Feinberg:

It's exactly what your question brings up. And I'm not an expert but I think Amsterdam 10 years ago had no bikes. And the city and the people decided to make it a bike city. And there are so many people biking that it's actually safe to bike there because every driver of a car also is a biker. And so they watch out for each other. And there's three stoplights. That's communities saying let's get healthy. And if we do that, we don't have to worry about opening more cath labs and we don't have to worry about getting Da Vincis if we can get people to ride bikes.

Ezekiel Emanuel:

Can I -- can I just say one other thing? The reason we're cutting back in schools is healthcare cost. Let's not forget it. States have fixed budgets. It's very hard for any governor to raise taxes. And when Medicare goes up and the healthcare costs for their state employees go up they have to cut something.

00:58:03

And where are they cutting? It's education. Collegiate education and tuition and support of the state university and primary and secondary education. That's why we're seeing those cuts that you mentioned.

John Donovan:  
Opposing[unintelligible] --

Ezekiel Emanuel:

And if we want better services there we have to get healthcare costs under control. It's an imperative for liberals and conservatives.

John Donovan:

Opposing team has the right to address that question or --

Shannon Brownlee:

Yes.

John Donovan:

-- I can move on to the next question. Would you like to address it?

Shannon Brownlee:

No. I'd like to address that question.

John Donovan:

So go ahead.

Shannon Brownlee:

It is -- it's absolutely imperative. Healthcare is effectively robbing state and local governments of the ability to pay for education, to pay for roads, to pay for social services. And it's -- and it's the waste in the system that's so extraordinary. So we're basically paying for proton beam machines in Washington, D.C., but we're not improving private -- we're not improving public schools in Northeast and Southeast Washington. And the question that I think we have to answer is what's the mechanism going to be for that transfer of that money?

00:59:01

So if venture capitalists come in and do a lot of -- a number of the things that Zeke is talking about were funded by venture capitalists. Because they're smart. They see \$1 trillion of waste in that system and they want to put at least some of it in their own pockets. They're not going to be giving it back to those communities. They don't want to give it back to the states and local governments. So what's the mechanism that's going to work? Is it democracy in this country? That's not working so well either. So we have to have this alliance I think between the good doctors and the good nurses and the good CEOs of hospitals, et cetera, et cetera, who want to see that change, and employers, and patients, and people in communities.

John Donovan:

Okay.

Robert Pearl:

And in a 15 minute doctor office visit you don't have any time to do the counseling on wellness, to move people along. We're continuing to train more specialists than primary care. There's a 10 year window between changing how we think about the needs of American healthcare system. And I don't think we're ever going to change it [unintelligible].

01:00:07

David Feinberg:  
All of our doctors --

John Donovan:  
Okay. Let's go to the next question.

David Feinberg:  
All of our doctors that see patients over 65 spend 40 minutes minimum with their patients.

John Donovan:  
Next question.

David Feinberg:  
So it's -- we can do it.

John Donovan:  
Next question please. And could you tell us your name?

Male Speaker:  
My name's Ben Tingee.

John Donovan:  
Thank you.

Male Speaker:  
In variation on a theme it's a similar question to the -- to the previous one.

John Donovan:  
If -- and I just want to say if it's too similar I might move on but let's hear what --

Male Speaker:  
Sure thing.

John Donovan:  
Okay.

Male Speaker:  
If improving the social determinance of health is so critical to fixing our broken system is our social services infrastructure up to the task? And if not, what would need to change?

John Donovan:  
Let's take that question. Shannon Brownlee:do you want to answer first?

Shannon Brownlee:

Is the -- is the -- I have no idea. I can't answer that question. Sorry.

John Donovan:

Okay.

Ezekiel Emanuel:

So I mean --

John Donovan:

That's a very honest response.

Ezekiel Emanuel:

-- what are the social determinants we need to --

John Donovan:

Zeke, you're not shy about taking that question.

Ezekiel Emanuel:

I'm not --

John Donovan:

You're going to go for it.

Ezekiel Emanuel:

I'm not shy about -- you know, we have a pretty good idea about the kinds of things we need to do. We need to raise incomes so people aren't financially insecure. We need to give nutritious food to people. And we need early childhood intervention so kids are actually -- we know that that produces better performance in school, reduces criminal activity later on, and gets people better jobs.

**01:01:15**

That is actually a pretty good formula. Can we do it? Yes. Again those are things we know how to do if our local government and our federal government made it mandatory. One of the things I've strongly advocated is that on Medicaid we should actually make nurse family partnership part of a requirement of Medicaid. Because we know 40 to 50 percent of kids are now born on Medicaid. And those families are stress and their parents need education about how to work with their children.

John Donovan:

Okay.

Ezekiel Emanuel:

That'll be phenomenal -- would have phenomenal financial returns. Seven to one, 10 to one.

John Donovan:

Robert -- Robert Pearl, jump in.

Robert Pearl:

Yeah. I think where we disagree is what I see happening is we're going to see more erosion because as people in a fee for service world try to bring down prices by trying to limit the unit cost what you're going to see is higher utilization so the total system won't solve itself.

01:02:05

And every system of coverage will deteriorate. And what you're going to start to see is people particularly at the lower ends of the economic scale having less and less access to care. You're going to watch the health deteriorate. It won't happen over the -- one or two or three years. Same thing, it takes five to 10 years, but we're going to see an ever-increasing society. Today, one in three people have diabetes or prediabetes. And I'm not seeing us change that as a nation. Geisinger might, Kaiser might, the exceptions might. The 30 million people covered by these kinds of plans that Shannon and I are talking about, but the rest of the nation has not made the progress as 90 percent of the country.

David Feinberg:

You don't think it all goes to manage Medicaid? And in managed Medicaid, you have to do those things. You think if they do block grants to states, states are going to say, we're going to keep this crazy fee-for-service system? For sure, Robert. It's going to a managed system where you're going to have to address those social determinants of health because that's -- otherwise you're going to just drowned.

01:03:01

Robert Pearl:

I agree that's what would happen. What I think's really going to happen is, no, they're just going to basically ration care.

John Donovan:

Okay. I want to go to another question. I want to take note of the fact that there are four men and one woman on the stage and in the next line, there are four men and one woman, but she's in the back. So why don't -- if you don't mind, I'd like to move you forward if you're not embarrassed by -- if I'm not embarrassing you by that.

David Feinberg:

There's other women.

John Donovan:

Thanks.

David Feinberg:  
There's at least two other.

Ezekiel Emanuel:  
Two other.

John Donovan:  
All right.

Female Speaker:  
So -- so I have heard a lot about the social determinants of health, which I agree is very important. What I'm curious about is, for these private integrative health systems that are clearly making a profit, what are you doing to give money back to the community and to support the 28 million uninsured Americans?

David Feinberg:  
We're giving food, we're giving housing, we're giving health literacy. We're giving -- I think Kaiser --

John Donovan:  
The reason I'm stepping in is I don't think you guys are going to disagree about that problem. And our disagreement is really about, is the system broken.

Shannon Brownlee:  
But I'm going to disagree with one thing. I don't think that it's -- I don't think that having the hospital do that is the right way we ought to be doing that.

01:04:09

[applause]

John Donovan:  
So -- so -- but how does that --

[applause]

Shannon Brownlee:  
I mean, that's -- that is a Band-Aid on a social problem.

John Donovan:  
Shannon, how does your answer play to the thing that we're arguing here?

Shannon Brownlee:

It's simply that -- that when health care is -- is effectively robbing our state and local and federal governments of the money to be able to do -- to provide these kinds of services, to provide education, to provide housing, et cetera, et cetera, then we have to find a way to extract the money out of the system. We can't just have -- keep the money in the health care system and then have it do its little bit for, you know, giving to community services and giving a little bit to housing.

David Feinberg:

Hippocrates said "Food is medicine." Kaiser spends 3 percent of its entire revenue on giving back to communities and social determinants and building walkways and affordable housing and making sure that there's farmers markets.

Shannon Brownlee:

Kaiser could have done a lot more.

Robert Pearl:

Because legally it is required to by the federal government or the tax rules, and that's what we're saying. We need major intervention to drive the system in the right direction, make it 4 percent or 5 percent, and make it affect everyone in health care and now you'll have the money that we need --

01:05:12

John Donovan:

So you disagree that major intervention is needed. The term they're using, "Major intervention."

David Feinberg:

Major intervention is happening. We're talking about major intervention.

Shannon Brownlee:

But it's not. Kaiser made a billion dollars in profit last year.

Ezekiel Emanuel:

Can I -- can I --

Shannon Brownlee:

And they put 3 percent into -- into food?

Male Speaker:

3 percent of revenue. That's -- that's \$3 billion.

Shannon Brownlee:

Okay.

John Donovan:  
Wait a second.

[Talking simultaneously]

John Donovan:  
Wait. Hold it. Hold it, hold it. We can't all talk at once.

Ezekiel Emanuel:  
It doesn't work to follow smart money.

John Donovan:  
Zeke, hang on a second. We can't all talk at once. So let me start it out. You'll go first, and then we'll move back to this side. Go ahead, Zeke.

Ezekiel Emanuel:  
One of the things in business, it says, "Follow the smart money. Follow where investment is happening." And the smart money in venture capital has shown that over the last -- since passage of the Affordable Care Act, investments in improving the American health care system, not producing more drugs or devices, but in actually improving the quality of the system and lowering costs, has gone up by 32 percent.

01:06:02

A lot of venture capitalists, as Shannon says, see opportunity in the health care system to make it more efficient and get rid of unnecessary care. Yes, they want their cut. But one of the factors is, if you make it happen, lots of people are going to save by reducing the costs and improving the quality, not just patients, but also the federal government, private payers and others because the way we care for patients throughout the system will change.

John Donovan:  
Robert.

Ezekiel Emanuel:  
This is -- takes time. And we're at the early stages.

John Donovan:  
Okay. I'm going to call time -- I'm going to call time to bring in Robert Pearl.

Robert Pearl:  
So you're absolutely right, 32 percent is almost nothing. It's not a whole lot of money. The biggest thing right now, show me a hospital that's not expanding, that's not building, that's not

buying high-cost technology. These investments are being made for the most part in Silicon Valley. I live there. And very expensive systems designed to make a lot of money. It's not being invested in the communities, in the wellness programs. It's not being invested there in the big dollars --

01:07:00

David Feinberg:

So, Robert, you've got to leave Silicon Valley. So I left Beverly Hills, and I went to central Pennsylvania. And in central Pennsylvania, we are converting hospitals and getting rid of cath labs and making them multi-specialty clinics that are focusing on primary and secondary care.

Ezekiel Emanuel:

Hospital beds are going down in America, a lot! And let me give you an example. When did we reach the peak of hospitalization in America? 1981. We had 170 hospitalizations per thousand patients. We're now down to 109 hospitalizations per a thousand American people. And the fact is, we are getting people out of the hospital. We're closing hospital beds just contrary to what

Robbie said.

Robert Pearl:

The major --

John Donovan:

I'm going to -- I want to -- I'm going to move on to another question. Sir, if you could step up. Thank you very much for your question. If you could tell us your name, please.

Male Speaker:

John Cuddyback with AMGA. For scaling up, do we need a uniform national person identifier for health care? And if we do, is that politically feasible?

John Donovan:

So you're talking about basically, what the layperson would call an ID card, something like that for every patient in order to scale up the system for the kind of vision that everyone's talking about here? Let's take the question first to this side arguing for the motion. Who would like to take that?

01:08:09

Shannon Brownlee:

I don't think it's necessary, but I don't think it's a bad idea. You could have your -- all your banking information on a little card.

John Donovan:

Robert, do you agree with that?

Robert Pearl:

Yeah, I -- what's essential is that we have everyone's electronic information available to every physician and hospital at the point of contact. Unfortunately, we're a long way away from that. We disagree on how likely it's going to be. I think a small card with all that information won't be enough. You need to have information -- you need to know whether my dad had his vaccine or not. And that requires every physician -- interconnectivity is not going to be enough. We need to actually drive a single national IT system like we have ATMs.

John Donovan:

Let's hear from the other side. Feinberg.

David Feinberg:

Come back to this conference in three years, everyone will have, on their iPhone, all their medical record, be able to share it with anyone. It'll be completely interoperable and useable. I think you can probably even be able to sell some of your information, de-identified or identified because there's value in that data.

01:09:00

John Donovan:

So the panel all agrees that actually that's a good thing, that everybody's -- okay. I want to move on to another question.

Male Speaker:

Hi. Matthew Gardner. And I wanted to go back to the idea of terminal. Terminal -- I'm not a doctor, but this is kind of how I see it. It talks about the strength to heal oneself relative to the trauma required to heal. So I'm wondering, while there may be some isolated solutions to heal health care, will the system overall be effective soon enough?

John Donovan:

All right. Zeke, you're saying, 2030 you think this is happening. What gives you this 2030 confidence? And then I want to let the other side respond to it. That's pretty soon.

Ezekiel Emanuel:

Well, it's 13 years. I think we're well on our way to doing two things: Changing how we pay, and responding to those changes with practices that we know can, if applied, consistently lead to higher quality lower care. And the real issue here is, are we going to have more payment change and can we get more adoption and transferring of those practices.

01:10:08

And that's not impossible. Remember, 13 years from now, the people who are coming out of training will be about 45 years old. And they are going to be -- they are implementing it, and they're going to be the dominant force in the health care system.

David Feinberg:

13 years ago, we had -- we had 30 million Americans who didn't have health insurance. We have made changes that people didn't think we could make.

John Donovan:

Robert Pearl.

Shannon Brownlee:

How many are uninsured today?

David Feinberg:

12 million, is that the right number?

Robert Pearl:

I think that's an amazingly great question. It's the trauma to heal and the trauma of the transition. Had we had health care costs parallel GDP for the last 20 years, we'd have 5 million fewer jobs in the United States. We'd probably have a dramatic reduction in hospitals. It would have been very traumatic. We didn't do that. Upton Sinclair said, "It's very hard to get a person to understand that which will affect their income." And I think that that's the problem that sits in place.

01:11:00

Now, everyone agrees about the things that need to happen. But when you look at what's really happening, hospitals and physicians are finding ways to consolidate to raise prices. Drug companies are consolidating to raise prices. The kind of resistance to that pain.

Ezekiel Emanuel:

Excuse me, Robbie. Maybe you haven't looked at the health care cost data recently. But contrary to what you just said, since passage of the Affordable Care Act, health care costs have been flat as a percentage of GDP. Flat. 17.5 percent in 2010, 17.5 percent in 2016. We have seen, actually, a flattening of the health care costs. We have not seen the continued increase. We have seen efficiencies in the system, and they are propagating.

John Donovan:

Okay. But, Robert --

Ezekiel Emanuel:

The past is not prologue to the future --

John Donovan:  
Let Robert respond.

Ezekiel Emanuel:  
-- and we need to change.

John Donovan:  
Also, I want to take on -- part of that question was the term "soon enough." Will the change come about "soon enough"? And that's gotten a little bit lost.

Robert Pearl:  
So, Zeke, you and I disagree. I think a lot of the things we saw was having to do with the recession that occurred, the downcrease that happened in cost of labor and other things. Those are one-time effect. Just read about the increase that's going to happen next year. Double digits are happening.

01:12:05

The issue is -- soon enough. And I think what's going to happen is, is that there's going to be a progressive erosion far sooner than our ability to make the change. We'll have to wait for the next recession or something else in our country, and then the crisis will happen.

John Donovan:  
What will that crisis look like?

Robert Pearl:  
The crisis will look like insurance going away, the government reducing dollars so far that people can't get the care. And I actually believe the possibility that we'll see true disruption from offshore competitors.

John Donovan:  
Response to that dire scenario?

Ezekiel Emanuel:  
Look, we have had flat healthcare growth because we've had efficiencies. We have not had double-digit increase, and we are now eight years after the recession. It's long past the recession. It's because the private market is changing and creating different incentives because Medicare and Medicaid are changing and creating different incentives. And the hospitals and doctors are responding. Are they responding fast enough for Robby and myself and Shannon and David? No.

01:13:04

We'd like them to do it faster. But the change is happening. And when you're shifting a \$3.4 trillion ship, that's the fifth-largest economy in the world, it's going to take 10 years. But 10 years is not never.

Robert Pearl:

But, Zeke, what's happened is that Medicare and Medicaid have paid less and less because they have the ability to do that pricing. The commercial world is now paying 130 percent of the cost. They're not going to tolerate it for very long. Something major has to happen, and I believe it will happen through the patients and through the major purchasers.

Ezekiel Emanuel:

Robby, again, the data just don't bear you out.

Robert Pearl:

[Unintelligible]

John Donovan:

Let me stop it for a minute.

Ezekiel Emanuel:

The per-person cost on Medicare have come down and are negative. The per-person cost on Medicaid --

John Donovan:

Okay, we're getting repetitive, and that's why I want to jump in. And I want to say this. I want to remind you again that we are taking questions and answers in this Intelligence Squared U.S. debate right now. I'm John Donovan, your moderator. And we have four debaters, two teams of two, debating the motion the U.S. healthcare system is terminally broken. Next question, please.

01:14:00

Female Speaker:

Hi, so I'm Laurie Skinner [spelled phonetically], and this question is, in regards to MACRA and other quality -- or quality metrics, Dr. Pearl, you made the comment that quality may not reduce overall cost. Can you please explain? And if it will not impact our current healthcare system, why are we spending all this time measuring it?

David Feinberg:

Yes, could you explain that, Dr. Pearl?

Robert Pearl:

I'd love to explain it.

David Feinberg:  
The quality [unintelligible].

Robert Pearl:  
First of all, what I said about MACRA is it's so complex that I'm not sure that people even understand all of it, the amount of time that it's going to take to provide the data is going to be discouraging? And they'll do it to get the payments, but I don't think it will change the underlying piece that sits in place. So why are we doing it? Because it saves lives. If you move hypertension from 55 percent, where it is in the United States today, to 90 percent, where the Geisingers and the Kaisers and the Mayos are at, you lower your chance of stroke by 40 percent. It doesn't lower total costs.

David Feinberg:  
That doesn't lower total costs.

Robert Pearl:  
[Unintelligible]

John Donovan:  
Let Shannon break in, please.

Shannon Brownlee:  
So, but there's another problem with the quality metrics. A whole heck of a lot of them don't have anything to do with actually improving patients' health.

01:15:01

They are -- the metrics that we have -- and so I think quality metrics are probably not a bad idea, but let's get the metrics that actually matter to patients' health and let's not have quality metrics that drive physicians to do things that are actually counterproductive, which is what's happening to many -- with many of these metrics.

David Feinberg:  
Shannon, do you think the quality movement is going in the direction you just said?

Shannon Brownlee:  
I don't see it.

David Feinberg:  
Oh, I think we're going way better from checklist and process to more outcome. I think it's happening.

John Donovan:  
I can take one more question.

Ezekiel Emanuel:

Can I make two points to this? First of all, MACRA is not just about quality.

John Donovan:

Zeke --

Ezekiel Emanuel:

It's got four measures, one of which is quality, but one of which -- which is supposed to grow over time -- is about resource utilization and getting doctors to focus on resource. The second thing is, quality measures are expanding. I'm an oncologist. You're now being required to do preferred chemotherapies, not any chemotherapy you like. You're now being required to measure patient-reported outcomes and makes sure they're actually getting back to work, feeling better.

01:16:02

We are moving exactly in the direction of meaningful outcomes -- not just meaningful health outcomes but meaningful outcomes to patients, and that is a positive effect. [applause]

John Donovan:

One more question, please.

Female Speaker:

Thank you. Julia Wang [spelled phonetically] from Mayo Clinic. Dr. Feinberg and Dr. Emanuel have provided a pretty convincing argument that the new payment initiatives are working and will work.

Ezekiel Emanuel:

We agree.

David Feinberg:

We agree. We'll invite you up here.

Female Speaker:

The bundle payments -- the bundle payments and the ACO, et cetera. The question that I have -- and I would enjoy a healthy debate on -- is, if all the providers in this country become good at managing risk and become risk-bearing entities, will that solve our fundamental issue and turn the health system around?

John Donovan:

Let's take the other side first. Robert Pearl.

Robert Pearl:

So, first of all, I mean, these things don't even actually happen till 2019, so I totally disagree that it's had this salutary impact. It's talked about, it's thought about, et cetera. If it actually works, if we're actually able to change it, it will have a very good impact upon the health of the country.

01:17:02

I'm just still very skeptical that people will do it. They'll fill out the checkboxes and make the things happen. I don't think they're really going to change the underlying social determinants, the other wellness factors, all the other things that go on, unless every one is a checkbox and now you're going to totally swamp the primary care physicians of the United States for which we already do not have enough of them.

David Feinberg:

Well you know, your question is a great one. And if everybody did the right thing we solve another problem. We have a provider shortage. And if everyone does the right thing all of a sudden we don't need as many doctors as we currently have. So I think that that's an important piece in all of this. We're -- we especially in some rural areas and in underserved areas trying to find primary care, specialty care, is almost impossible. Pediatrics have specialists. If we can get docs -- and the choosing wisely is another example of docs coming forward and saying let's do the right thing. And you can poke fun at it but it has improved care and it has come from the bottom up. Will allow us to have more providers because we eliminate that unnecessary care.

01:18:07

Robert Pearl:

David, wait a second. We don't have a shortage of physicians. We have too many specialists and not enough primary care physicians in the United States today. In Philadelphia there's what seven medical centers sitting there. We don't need all those pieces. We need to come together with enough volume to do things well. That's the change that needs to happen and I think you're absolutely right. The rural areas it's tough to get people to go there.

David Feinberg:

Sixty-five percent of America lives in rural areas.

Robert Pearl:

I understand.

David Feinberg:

No.

Robert Pearl:

It's tough to get them to go there. We have a redundancy of specialists, a redundancy of hospitals, and insufficient primary care. We need twice as many primary care. We're not training them. And we're making their lives miserable right now.

John Donovan:

And that -- and that concludes round two of this Intelligence Squared US debate.

Ezekiel Emanuel:

How did he get away with --

John Donovan:

-- where our motion is the US healthcare system is terminally -- is terminally broken. You were saying how can he get away with that? You can --

Ezekiel Emanuel:

With that assertion.

John Donovan:

You can address it in your closing if you have time.

Ezekiel Emanuel:

Thanks.

John Donovan:

You've got two minutes. And that's how it's going to work.

Ezekiel Emanuel:

So [unintelligible] decide.

01:19:02

John Donovan:

Now we move on to round three. Round three will be closing statements by each debater. They will be brief. They will be two minutes each. Again the motion is the US healthcare system is terminally broken. Making her closing statement first, Shannon Brownlee: senior --

David Feinberg:

Three minutes. You said --

Shannon Brownlee:

You said three minutes.

John Donovan:

You said I said three minutes?

Shannon Brownlee:

Yes.

John Donovan:

Two minutes.

Shannon Brownlee:

Okay.

Ezekiel Emanuel:

There's three minutes on the clock.

David Feinberg:

I think give them three and two and it'll balance it out maybe.

John Donovan:

All right. You know, do you guys want -- can you like vamp for another three minutes?

Ezekiel Emanuel:

Two minutes. [unintelligible]

John Donovan:

Are you -- would you -- are you going to die if it -- if it messes you up?

David Feinberg:

Terminal.

John Donovan:

Whoever needs three minutes take it. Try to be as short as possible. If there was a misunderstanding and it's our fault we'll give you that concession. One more count for this side. You must think I'm leaning over there but I'm really not.

Ezekiel Emanuel:

Yeah, we do think so.

John Donovan:

No, I'm really not. Making her closing statement for the motion, Shannon Brownlee: senior vice president of the Lown Institute.

Shannon Brownlee:

Thanks. So I think Zeke has kind of painted me and Robby as the bad news bears. It's all doomed. Everything's terrible. Everything's lost. And in fact that's not the way I think. That's

not what I believe. I believe we can have a truly great and uniquely American healthcare system. And not because Winston Churchill once said Americans eventually come to the right answer but only after trying everything else.

01:20:20

We can have a great healthcare system because of all the examples that Zeke and David have brought up. And we can have a great healthcare system I believe because of all the physicians I know. There's three of them in this -- on this stage who -- and the nurses and the physicians assistants and the pharmacists and the regulators? There are all kinds of people in healthcare who absolutely committed to making a better system. The problem isn't a deficit of know-how and the problem isn't a lack of good intentions. It's what it's going to take to move the entire system.

01:21:01

And many of the examples that Zeke offered are dependent on venture capital. They're -- or they're dependent on somebody investing money up front. And I want to see that money return to communities. I want to see that money return to patients. I think that money needs to be returned to state and local budgets.

And that's one of the pieces that we haven't figured out. David has made the point very clearly and very eloquently that the health really is going to lie in these social determinants. That healthcare needs to be reserved for taking care of people when they are sick, but we can prevent a great deal of that by reinvesting that money. And we can't do that right now if it's being sucked up by the healthcare system. But the really big issue here is this need for a radically different system is not going to become a reality until we become honest about what's really wrong with the system.

01:22:03

Now we all know what's wrong with the system. We all know what's wrong with the system out in the audience. But the American public doesn't get it yet. And we need to start talking to them. And I want people to get out of their clinics and out of their hospitals and out of their offices. And I want them to start talking to their friends, to their neighbors, to their -- to their relatives, even the ones who voted for the wrong candidate. I want them to start talking at their churches and their mosques and their synagogues about what's really going on in health care and what a truly great system could look like. Because if we don't do that, we dishonor the suffering that's still going on. We dishonor the people who are being hurt by the system. So the gulf between the system that they've described and the system that we have today is so wide that I think you have to vote for the premise, "The U.S. health care system is terminally broken," but it can and will be fixed.

01:23:02

John Donovan:

Thank you, Shannon Brownlee.

[applause]

John Donovan:

And that's the motion: The U.S. health care system is terminally broken. Making his closing statement against the motion -- and we will, if you need -- if you want to take more time, you've been very sportsmanlike about that, and we appreciate it. Zeke Emanuel, vice provost of Global Initiatives at the University of Pennsylvania.

Ezekiel Emanuel:

Well, we just heard Shannon say the U.S. health care system can and will be fixed. I think the debate's over. She's just agreed with our side. Yes, the system underperforms. Yes, the system has got a lot of problems, monumental problems. And this side has been well -- has well documented them, not just at this debate but throughout. That we need strong medicine, we agree. But that does not mean we're terminally ill. There are lots of points of light out there. And one of the important points I wanted to make is, in the provider community, among doctors, hospitals, health systems like Geisinger and Kaiser, we have lots of innovation going on out there.

01:24:01

And that innovation is not limited to just the big giants who can afford it because they have revenues in the billions of dollars. Small practices are doing it. Intermediate hospitals are doing it and many other groups. That's the first point. The second point is, we have a lot of investment from venture capitalists and the smart money developing lots of innovations in areas we have never seen attacked before. Primary care, lots of places like Iora and Village M.D. and others. Mental health services, we've seen new companies to bring mental health services to people. And as I mentioned Aspire, end-of-life care and palliative care, who would have thought, 10 years ago, you'd have new companies in these spaces to transform the system? Change is happening from below, those new companies, those practices with new ideas. And it's being propelled from above by payers who are saying we need to adopt those things, and we're going to pay you differently.

01:25:03

More and more health systems are being at risk, and they're going to change how they pay their doctors to be at risk so that they have a stake in the finances as well as the quality. That's happening in the private side. It's also happening through Medicare. Robbie says, "Oh, MACRA's so complicated." It is complicated, but the fact is, people have two choices. Both choices, whether they go with MIPs or they go with alternative payments, force them to now be cost conscious, to actually be efficient, to get rid of unnecessary care and to improve their quality. That's the direction of the future. Yes, Robbie says, "It starts in 2021." That's 10 year

before 2030 last I looked. And that means we will have one of the world's best health care systems by 2030. Is that too late? We will have squandered a lot of money, all of us agree. But it does mean we can transform.

01:26:02

Now, let me conclude with one element why I am wildly optimistic about the American health care system. It's called the judgment of Paris. In 1976, there was a battle over the best wines, California versus France in Paris France, with nine out of the 12 judges being from France. California won. California used to produce junk wine, and then it became the world's best. The American health care system's going to be exactly like California wine. We're mediocre. Soon, we're going to be the world's best.

[applause]

John Donovan:

Thank you, Zeke Emanuel. The motion: The U.S. health care system is terminally broken. And making his closing statement in support of the motion, Robert Pearl.

Robert Pearl:

So the commonwealth fund last month put out its review of the global health care environment. United States was number one in cost for the 10th year in a row. We were last amongst the 11 industrialized nations. We are last. It's a huge gap to close.

01:27:01

We all agree on where we need to get to, to size the gap is what we disagree around. We've got to get rid of fee-for-service and move to capitation so physicians have as much incentive to prevent a heart attack and a stroke as to treat it. We need to be sure that we have every American with electronic record so we can avoid medical error and increase the quality. We need to elevate primary care and the number of primary care physicians. Get rid of the 15-minute visit and rebalance the ratio. We need to do something effective around drugs. And that's going to have to happen at the federal level. And I'm concerned for the health plans, the hospitals, the major physician societies, the drug companies are all going to oppose this. And we've underestimated that resistance. The problems are great. Costs are growing twice as fast. Small hiatus of time they're, once again, growing twice as fast as ability to pay. Hundreds of thousands of people are dying every year from preventable problems.

01:28:04

Primary care is becoming unsustainable and getting worse. Drug costs continue to rise. But it's not just that. At the end of my father's life, my brother and I got a phone call. He had a bleed into his brain. We hopped on a red eye. We flew to Miami. There he was strapped in his bed, intubated. Out the door was a line of doctors. The ENT doctor wanted to do the

tracheostomy. The GI doctor put the feeding tube in place. The neurosurgeon take out pieces of his skull. We looked at the X-ray. He's not getting better. We said, "Thank you for your care, but no thank you." For the next two and a half days, we never saw another physician. There is no fee-for-service code, CPT, ICD9 code for compassion. There is no way to get paid in the American health care system today to be with a family in its time of greatest grief. The first thing is acknowledging that the system is terminally broken, then having the courage and having the leadership to make the changes to make it once again, as it should be, the best in the world. I urge you to vote for the motion so that the hard work can begin. Thank you very much.

01:29:13

[applause]

John Donovan:

Thank you, Robert Pearl. And one more time, that motion is "The U.S. health care system is terminally broken. And here making his closing against the motion, David Feinberg, president and CEO of Geisinger.

David Feinberg:

25 years ago, my wife and I had our first child. And I was pretty sleep deprived. I was a second-year fellow in psychiatry. And I was telling a father, he happened to be a used car salesman. He sold Cadillacs in Vegas. But they brought -- he had brought his son. He was a single dad. The mom had left. He brought his son to UCLA because he had his first psychotic break. And I had a very, very small office as a fellow. When you opened the door, I actually had to bend -- move the chair so that I could put the chair back after I closed the door. And I thought I was really smart. I had been trained at great places. And I talked to this dad about neurotransmitters and dopamine and re-uptake and anticholinergic and all the things that happened with the first psychotic break.

01:30:03

And he looked at me, and he said, "Are you telling me I need to build a room out back?" And I started crying because I was sleep deprived. I had a new baby. And I realized that the trajectory in this family's life had changed dramatically. And from that point forward, I said, "I'm going to talk to patients in a way that they understand. I'm going to assure -- make sure patients get compassionate care." A few years later, I saw a third grader who had tied yarn around her neck. She actually wrote in a haiku poem that she wanted to tie yarn around her neck and commit suicide. Because the family knew somebody, they were able to get in within three weeks. Picture yourself with a third grader that writes in her haiku poem that she wants to kill yourself, and it takes three weeks to get in, and that's because you had an in. From that point forward, all I tried to do is improve access so that every patient could get in the same day. If you strip down what we do, we are simply people caring for people. It's going to take

us, all of us, to change the system. I'm all in, and I hope you will come on the journey with us. Thanks.

01:31:13

[applause]

John Donovan:

Thank you, David Feinberg. And that concludes closing statements in this Intelligence Squared U.S. debate. And now it's time to learn which side you feel has argued the best. We want you to go to your phones again and vote a second time to tell us where you stand on this motion, "The U.S. healthcare system is terminally broken." If you go to the -- to the address on a browser that you see on the screen, IQ2US.org/vote, you will be given prompts to work the app, and you can, once again, vote "yes," "no," or "undecided." And I will get the word pretty shortly. I have an iPad up here that will be alive and will have the information pop up. But until that happens, I want to say this about this debate that you just witnessed.

First of all, I want to, for a second time, thank Zeke Emanuel for -- having inspired the debate. There's a reason we've had you back a second time.

Ezekiel Emanuel:

[laughs] I'm a loudmouth.

John Donovan:

Well, I -- no, you're a very, very spirited debater. But your book, "Prescription for the Future," as I said, inspired this debate.

01:32:09

Ezekiel Emanuel:

Thank you.

John Donovan:

But I wanted to let the audience here know that we're going to provide copies of that book to the audience. They're on us, and we want to do that as a way of showing -- thanking you for that.

Ezekiel Emanuel:

Thank you very much.

John Donovan:

Thank you very much. [applause]

Ezekiel Emanuel:

I really appreciate it.

John Donovan:

The other thing I want to say about this debate is, as I said at the beginning, it's the goal of Intelligence Squared to really show that there's a way for people to disagree, but disagree in a way that sheds light and that can take place within a framework of civility and mutual respect. And as fierce as the battle was on this stage, there wasn't a single moment when you doubted that -- whether these debaters respect one another. They surely do.

They surely showed that. And what you demonstrated is something I think that we can all applaud. Thank you very much for what you do.

[applause]

01:32:59

And then the other entity I want to -- I want to acknowledge is the Mayo Clinic and this conference, the Transform conference. It's been such a spectacularly good partner for us. They worked very, very closely with us at figuring out what to debate, what this debate should be about. It went through a lot of different ideas and a lot of research and a lot of discussions back and forth. It was all constructive, every step of the way. We learned from them. I think that they learned from us. And I really feel that this is one of the most exciting debates we've ever put on as a result. It was a pleasure to be doing it in front of all of you. So thank you so much to the Mayo Clinic and the Innovation conference and Transform for having us.

[applause]

So it just hit my iPad. The votes are in. Here's how it works. You voted twice. It's the difference between the first vote and the second vote. Whoever went up the most who -- will be named our winner. The motion again: The U.S. healthcare system is terminally broken. On the first vote on that, 42 percent of you agreed with the motion, 34 percent of you disagreed, and 24 percent were undecided. Those were the first results. Let's look at the second result.

01:34:03

And the second result: The team arguing for the motion the U.S. healthcare system is terminally broken, their first vote was 42 percent, their second vote was 45 percent. They picked up 3 percentage points. That is now the number to beat. Let's see the team against the motion. Their first vote was 34 percent. Their second vote was 51 percent. They pulled up 17 percentage points.

[applause]

That's what it takes. The team arguing against the motion the U.S. healthcare system is terminally broken, our winners. Congratulations to them. Thank you from me, John Donovan, and Intelligence Squared U.S. We'll see you next time. Thank you, everybody.

[applause]

01:34:45

[end of transcript]