[00:00:01.290] Announcer:

Welcome to APG on American Healthcare, the official podcast of America's Physician Groups, where we discuss current issues in the healthcare value movement. APG members are at the forefront of national healthcare reform, practicing at risk-based prospective payment and other population-based payment models, the very models described by federal legislation for the entire nation. And now for an inspiring and educational look at the transformation of America's healthcare delivery system, here's your host, APG President and CEO Don Crane.

[00:00:36.630] Don Crane:

Hello, friends. You are about to hear a podcast interview I did just the other day with Don Berwick, known well,

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I think, to all of us. He is, I think, assumed almost legendary status in the value movement and maybe more broadly in American healthcare. He is a longtime advocate for value and prospective payment. He was the founder and CEO of IHI, the Institute for Health Care Improvement. He was the administrator of CMS just when the Affordable Care Act was enacted. And that was particularly important because it was he who initially set up CMMI, right? Center for Medicare and Medicaid Innovation and so he, through all of that work, really put Medicare and I think this country on a much faster track towards value. So, his perspective today, I think 10 years later, is particularly important. So, listen, if you will, though, to his discussion with me regarding quote-unquote, incumbents and whether they are going to be moving us into value or not, he'll define incumbents. And this is good. I regard it as a very important discussion, because if the incumbents aren't prepared or interested in moving into value, we have a serious barrier in front of us suggesting the need for much, much, much stronger incentives to create much stronger business case for moving into value, positive incentives, negative incentives that really make this happen. So, at any rate, take a listen. I think you'll enjoy it. In the meantime, stay safe and healthy.

[00:02:30.900]

Don Berwick, so nice to have you with us here today. You're the President Emeritus and Senior Fellow at the Institute for Healthcare Improvement, an organization you co-founded and led as President and CEO for 19 years. You served as the Administrator for CMS from July 2010 until December 2011, a particularly critical time coming shortly on the heels after the passage of the Affordable Care Act.

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You're an elected member of the National Academy of Medicine, formally Institute of Medicine. And if all of that wasn't enough, in 2005 you were appointed the Honorary Knight Commander of the British Empire by Her Majesty Queen Elizabeth II, the highest honor awarded by the UK to non-British subjects in recognition of your excellent work with the British National Health Service. The value movement has

many fathers and mothers and architects and heroes, but you most certainly are at the top of that distinguished list.

[00:03:32.640] Don Berwick, MD:

So, I'm really privileged to have this conversation with you today. So, welcome.

[00:03:36.540] Don Berwick, MD:

Very kind of you, Don. Thanks. I'm glad to be with you.

[00:03:38.820] Don Crane:

So, I'm going to dive right on into it.

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I'll skirt right over COVID pandemic's and the like and get to the topic that is of most interest to me, Don, and it's the value movement. So, you know, if there are recognized figures as being sort of, you know, fathers of the value movement, I'm sure you're cringing if I try to upend that appellation on you and maybe that's a little much. But indeed, you know, you are highly associated with it. I think of our mutual friend Ian Morrison, who sometimes refers to the Berwickian vision of physician groups, blah, blah, blah.

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So, anyway, you have that tag. And so, I think it's a good one.

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So, I'll just start by tell us what you think of the progress of the quote-unquote value movement as we're seeing it today.

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Affordable Care Act passed in 2010, MACRA 2015, lots of pilots and demonstrations out of CMMI, certain amount of activity in the private sector. How would you assess where we are today? Good, bad? Somewhere in between?

[00:04:47.970] Don Berwick, MD:

It's hard to make a single assessment because it's such a zoo of different approaches that all come under the rubric of the value-based movement, as you put it, Don. Let me take a step back to what I think of as the fundamentals. My career has actually been spent a lot more dealing with how healthcare delivery

should change than on how healthcare payment should change. So, I would judge any change in the circumstances of healthcare, and the environment of healthcare with respect to its effect on our care delivery.

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And I always use 4 tests, which is

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does this help us get closer to universality, toward healthcare as a human right? Second is, will it help improve the quality of care? We have major deficiencies in health

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care quality. And that's what I've been devoting my…really my life to, my career to, for decades, improving quality. The third question is, will it move us toward what are currently referred to as social determinants of health? Will this help us devote resources, more resources, much more resources to mitigating the things that make us sick: environmental conditions, early childhood experiences, our education system, infrastructures and communities and so on, and then, last, will it reduce cost?

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Right now, I regard the overall cost of healthcare as confiscatory. It is highly excessive. We're spending so much more than any other country, and we don't really need to. We could have much, much better care than we do today for everybody at a lower, total cost. So those are my four tests. Will it be move us toward universality, will it improve quality? Will it help us reinvest or invest far more in social determinants? And will it reduce the total financial burden of healthcare so we can devote resources to other uses?

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So, when you ask me how are we doing on value-based care I'm thinking, well, those are, that's the same question to me. How are we doing on that? And I would say we are still in a very early stage, adolescent at best, and the results of trying to change payment in terms of what people are calling value. They're mixed, and I think it's a wonderful time for reflection. We've had 10 years at the federal level, of course, in California, much, much more. You've been at this a lot longer than other states.

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And I think we have a lot to learn. I would say, for the collection of attempts to move away from fee-for-service into new forms of payment that offer more opportunity to do the right thing. It's a mixed bag, and I think I wish we were seeing more progress than we are. That said, I think that especially if we look at

what is happening in other countries, not just ours, there is a lesson in here which is it's better to try to wean from fee-for-service.

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It's almost more about what we have to get away from than what we have to go to. But I think the fee-for-service system is unfit for the needs we have—those four needs. And I guess I tend to think that the closer we approach population-based payment, sort of more complete forms of alternative payment, I think the better we do, the better we can do. It's probably more than you wanted to hear at this point.

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But that's my overall read right now. A mixed bag, just still learning and highly incomplete.

[00:08:33.710] Don Crane:

So, that's exactly what I want to hear. I think those measures actually flesh out the word value very well. So, thank you for that. And of course, the overarching grade you give is kind of mixed, which strikes me as sounding, you know, C-plus, if that.

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And so, you know, we have been at this a long time. You know, we both refer to the Affordable Care Act being passed in 2010. So that's a whopping 10—or now pushing 11—years ago. And then clearly in parts of the country, referring to California, we've been doing this for 20, 30 years. So, you know, we've had a head start, a lot of time spent. But the progress has been, quote-unquote, mixed.

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And, so, I guess my next question is, why mixed? Why not excellent? Why not better than mixed? I mean, what are your views on the reasons for the quote-unquote, mixed? I would use the word slow, frankly, progress.

[00:09:27.680] Don Berwick, MD:

Yeah.

[00:09:28.940]

Well, you flatter me by asking because I'm really not sure. But here are two or three underlying reasons. One is that change is hard. Changing delivery is hard. If we wanted to have a healthcare system that really did the right job, we would be putting in forms of care and support to people to keep them at home

rather than in hospitals. We would be moving a lot of care out to communities. We'd be supporting much better coordination of care as a fundamental feature of care

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where teams matter more than individuals. We would be focusing on ways. We would be looking at everything we do and say, did that really help? And if not, we would stop it. That's all hard because we, you know, we get trapped in the habits of practice. The work of the Institute for Healthcare Improvement, the organization that I co-founded you referred to, really is about helping people to give healthcare change what they do when it's hard.

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The second is the legacy investments that have come out of the fee-for-service world are gorillas. They are 800-pound gorillas. They're in the room. We just built the new wing. We have to support it. This is the configuration of our staff. We really want to keep it that way. And when we think about moving toward the aims of integrated care that I'm talking about—universality, better quality, more social work and social determinants and reduction of waste—that threatens the legacy investments.

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The key one, of course, is hospitals. We have a tremendous amount of our healthcare world is invested in the hospital structures. And the implications of actually focusing on population needs are profound for hospitals. They actually would have to seek to be empty. And although many, many avow that goal, I think when you look at the C-suites and the business models and what the board celebrates and the contingencies for CEOs, it's still about keeping hospitals full, mainly.

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And that relates to the third barrier, which is the overall economic model, which is under the fee-for-service model, under the revenue-based model, the model in which topline growth is regarded as success. The interests are in spending, and that's how people make money and take a lot of money. And so, for every supplier, every member of the healthcare business team, doing more pays more. And it's very lucrative. We are a wealthy, wealthy industry on the whole.

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And people don't want to give up that money. They want to keep those sources of excellent revenue going. And so, it's all about raising prices and consolidation and sort of playing the fee-for-service opportunity well. Now that changes somewhat. There are changes here, and that's good. But we're trapped by the financing system and the legacy investments. I think the last is a massive problem that I do not know how to fix. I just really need a national dialogue.

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It has to do with that third of the four aims, which is shifting resources towards social determinants of health.

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I have the privilege of working, for example, on a Bill and Melinda Gates Foundation national project to help middle schools and high schools that are struggling. And I almost am embarrassed to be there because trying to understand how to take a struggling high school and really help those kids succeed. These wonderful leaders, the teachers and principals and district superintendents, they are using money that is two orders of magnitude less than what we have in healthcare.

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For them, pennies are the issues. And we know very well, very well, scientifically, that a strong education system contributes to health and well-being in a society. We know that. And that's not even incontrovertible scientifically. We know that investing in early childhood support contributes massively to health and well-being. We know that a good transportation system, food security in communities, is the underpinning of health for many, many people. In our country we perform really poorly on these social determinants.

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And the question is, where are we going to get the money? How can we help our schools really thrive? And that money's got to come from somewhere. I guess it's not going to come from higher taxes. Our country seems not willing to tax more. Where is it going to come from? Well, healthcare's got 18 percent of the gross domestic product, at least I'd say a third, probably a half of that is pure waste. If we were purely rational, we would move money from healthcare to things that generate health.

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That is a massive problem. We don't have the political will at the moment. We don't have the holistic view of investments in communities. We don't have the lobbying energies to overcome the status quo, vested interests, and that keeps us from reinvesting. So, as we try to move toward value-based payment with all of those things in mind, we are actually threatening a tremendous amount of infrastructure. And in the end, to be absolutely honest, that means moving resources from healthcare to other health-generating components of society.

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When you work with a fully capitated system where there's a budget for the health of a population, the dynamics do change. Then you have C-suites thinking about true causes of illness, waste, and how to

recover waste and reinvest it, but for that, you really need a holistic view of the budget and we don't have that.

[00:15:25.030] Don Crane:

So, Don, let me interrupt.

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Should any of this, or does any of this, surprise us? So, I think back to Sylvia Burwell's targets for the penetration of population-based payment across different products and programs. The LAN similarly has targets and goals and the like and all of which targets and goals we're failing to meet. And it makes me think, OK, so I, for one, probably figured that would be hard. We understand the legacy interests. You know, I think we've long known that more spending is lucrative for some.

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So, are we surprised by this as we adopted these goals or did we know exactly what we were going to get? And, you know, what's your view of that? Is this surprising to us or...

[00:16:19.300] Don Berwick, MD:

It's a wonderful question. I think no. I mean, it's you know, if you want to predict the future, look at history. And we have not shifted American healthcare toward universality and higher quality and social determinants or waste reduction as fundamental aims. So, one would predict probably it’s going to be hard to do it. I am surprised by one thing, and actually, Don, you're one of the experts I would turn to to help understand this.

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So, if you look at, to be narcissistic, my list of names—the universality, better quality, social determinants and lower cost—and you say “who would stand to gain if that, if our health and healthcare system, evolved in that direction?” And the answer is almost everybody fundamentally, certainly business would gain so long as we have employer-sponsored insurance. The gains for high-functioning health system for businesses would be massive, just massive, except for those, of course, that are invested in the status quo healthcare system.

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The gains for actually voters would be massive, especially people of lower income and lower health status. They would be far, far better off since the bulk of 50 percent or so of our healthcare payment is coming from government somewhere. You'd think governments would then finally have a little oxygen to devote their resources to what really matters to people. And since, in the end, every single dollar that

healthcare spends, every single dollar has only one source that only comes from one place in this country, and that is workers.

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Every nickel we spend in healthcare has come from workers through taxes, through out-of-pocket payments, through their contribution to their own insurance, to their, it's…that's the source. So, you'd think people would gain. So, I guess an amateur politician would say the massive coalition of interest to move toward authentic value-based care that achieves what we just talked about should be enormous. And I guess I am surprised the sleepiness, almost the timidity, of stakeholders who stand to gain so much is really, it's really quite something.

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The reason why not is, you know, that takes a political scientist, a sociologist, neither of which I am. But I think it's citizens united. I think it's the fact that the vested interests in the current system are so powerful politically. They just, they are all over this politically and they're very expert. They're expert in policy. And so, you have to kind of find a way to mobilize those latent interests. And we just have not done it in this country.

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That's not, of course, only true of healthcare. You might say the same of climate change or structural racism or poverty itself. We have strong shared interest in their alleviation, but we continue to, a friend of mine says, we continue to admire the problem instead of fixing it.

[00:19:31.290] Don Crane:

So, Don, you and I are on an advisory committee and along with a number of others and had a call the other day, maybe a week or two ago. And a couple of people refer to ‘incumbents.’ And there was the expression, the expressed view expressed that the incumbents aren't going to get it done. I think you may have been one of those that uttered those words, and I agree, frankly. So, as we talk about these vested interests, let me ask you the question.

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When without and I'm sure will be politic as we speak here, and I don't mean to disparage anybody hugely, but who are these incumbents that we're talking about?

[00:20:08.580] Don Berwick, MD:

Well, let's first talk about the non-disparagement that you just talked about. I think that's a really important point, Don. There certainly are evil-doers or greedy, greedy forces in healthcare. And, you know, I've

seen them act and they're part of the problem. But no, I think for most of what I called the incumbents, these are good people who believe strongly in what they do and are proud of it and getting awards for it and have grateful communities.

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And so, you somehow…addressing the problem, but resisting the moral polarization that is actually, I think, it's an important point to keep in mind. But, overall, the incumbents are people whose current sources of income for growth of capital depend on the current…are configured for the current system. You know, it's the hospital board that is used to growth as the thing to celebrate. It's the CEO that gets rewarded for growth. It's the....

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it's the finance people who have been trained to have a topline-driven, revenue-driven model of business success. It is profiteers, some of whom, many of whom, regard their job as getting the most payment they possibly can. That's their job. And they include the supply chain industries. They include the physicians and others who are constantly in the game of arguing that their payment has been cut too much. They're not getting enough. They're all trapped. They're all trapped by the by the payment system and a game they're very, very used to playing.

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You know, I was, I have a speech that I've been giving off and on and it shows how psychotic I have become, I think, because I say, OK, look, our heart attacks, our strokes, our depression, injuries in the streets. These are coming from these social determinants. Let's take a couple of them. How about hunger? We have right now in the COVID pandemic, I keep hearing different estimates, but something between 20 and 40 million Americans have severe food insecurity right now, 17 million children supposedly are hungry in this country.

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We have a rising problem of homelessness and eviction right now. We have over 600,000 chronically homeless people in this country and many more with housing insecurity. We have an opioid epidemic that's still raging due to structural conditions in societies that make desperation too common. These are all remediable. Every one of those hunger, homelessness, severe poverty that we know, they're remediable. We have nations that give us that example. So, look, here's my challenge: American Hospital Association, American Medical Association, State Medical Society, State Nursing Union—

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how about a suspension for the next three years? How about nobody spends any money asking for more money? Just stop it for three years and take every dollar you would have put into lobbying and organize

as the healthcare industry to go to Congress and say, we want an America with no hunger. An America with nobody without a home. An America where we have finally stopped this opioid tragedy. Take all that political energy and put it into making people healthy.

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The returns would be phenomenal. The gravitas of this industry is such that I think it would change minds and investments. But think of what that means. Think of how disruptive that would be to the what I would call the incumbents. It's not what they're used to doing. They could do it. But no, I would predict it'd be very unlikely.

[00:24:18.600] Don Crane:

So, question, this list of incumbents. Does it include health plans?

[00:24:24.450] Don Berwick, MD:

Yes, health plans. Health plans I sometimes think they're like batters at the plate and they hit the pitch we throw. So, the pitch we throw right now involves mostly fee-for-service payments and, you know, rules of coding and so on. And so, you know, they're pretty good at it. They are used to that. Some of them are claiming that they're changing their models to become more activists and trying to improve the health of societies.

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And I think that some are doing good work there. But on the whole, it's a cost-plus game. I mean, they're doing very well financially that depends on taking their share of the cash flow and they're good at it. They don't want to stop that. Watch what's happening with the public option. I don't know. I don't think statutorily it's likely to pass in the Congress as it's likely to be configured.

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But public option could be a chance for government to become an insurer for anyone that wants it and see how that goes. Maybe government is a better insurer. Medicare is very popular. No, what you see here is the insurance industry, the plans rising to the political challenge of making sure that the public option is just really an extension of Medicare Advantage, which is not the test we need. That's not the test we need. The test

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we need is of government to be the insurer and see how that goes. On the whole, I think, despite my friendships with the plans, I don't think they add value.

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I think they're just, they make money on transaction and it's from a viewpoint of the interests of patients, largely waste.

[00:26:13.330] Don Crane:

Good people, bad incentives, bad system, good people, would you,

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I think I've got that right. But next question. Be honest with me now. Do you see I'll just say physician groups without saying APG members or I'll ask it both ways. You see physician groups as being among the list of incumbents?

[00:26:34.780] Don Berwick, MD:

Yes, I do. Somewhat the same way that I was saying. Physicians are, they're playing the game according to the rules as written, which are all about getting more encounters, getting higher fees for their services. That's the way we set it up. I think that, I'm romantic about most physicians, and most physician groups are highly dedicated to actually trying to reduce suffering.

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And so, I think they go to work to do the right thing. But the conditions in which they're thrust, force them into behaviors, habits and then political positions that don't get us toward the four aims that I just talked about.

[00:27:22.900] Don Crane:

So, let's draw a distinction, though, between physician groups that are living on a fee-for-service world versus physician groups that are capitated. Does that change your answer?

[00:27:31.900] Don Berwick, MD:

It does.

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I am, I think physician groups that have learned to live with capitation and have…Don, you're more of an expert than me on this...but that don't…what would I say…don't disassemble the positive potential of capitation to their own internal payment systems. Physician groups that really are together as teams and

live in the capitated world are much more likely to be contributors to actually the evolution of care that we see. I mean, I wish I knew more of the groups that you work with every day.

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But, you know, one of the key ones that I know very well is Kaiser Permanente. And, you know, obviously Kaiser Permanente also is embedded in the status quo in some very important way. For example, I think on the whole, Kaiser continue probably shadow prices. It doesn't say how low could our prices be. It says, what is the ambient price and can we undercut it a little bit, which is not as ambitious as I would want.

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But if I actually go and watch, say, Northern California Permanente group, which I visited and think about what they're trying to do, it's what we need. I mean, they were years ahead in moving toward telemedicine and telehealth years ahead and figuring out how to use nonphysician caregivers to actually meet patients' needs better than some physicians can. Years ahead, in integrated views of team-based care, and that's because they had a budget and it was their budget and they could spend it pretty much as they want.

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And they were smart enough not to pass down the fee-for-service incentives too deeply into the system. So, I do think there's real potential there. The problem with physician groups, is more where…or a problem is more size its heft because you have to capitalize this. And I think physician groups, as most are configured, have trouble raising capital. They have to put a lot of money into wasteful transactional costs, which take money from care.

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But I think there's a lot of hope, maybe in physician group-led transformation of care delivery.

[00:29:43.510] Don Crane:

So, I think we know what we want and we see that some of the incumbents aren't well designed and incentivized. And let's get practical, Don. I mean, what do we do? Do we ask, can we reasonably think that Congress will intelligently create incentives or mandates to make the system move in the direction of the four measures you've identified? Is that a realistic thing? What other sort of tactical suggestions would you make for what we do to move this tanker around?

[00:30:19.310] Don Berwick, MD:

You're reminding me of my longtime board chair at IHI, Bob Waller from Mayo Clinic, always used to say everything's impossible until it's not. So, it sure looks impossible now the kind of changes we need to get us toward the four goals that I outlined are massive and politically very, very, very difficult. So, what are

some possibilities? One is, I think maybe local action that in geographic, smaller geographic areas where there's a more communitarian view of this, where you, when I say every nickel comes from workers, I mean people, you know. Not some anonymous people. It might be possible for and

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I'll take your point. Physician-led groups to begin to work with local payers, the local population on those four aims that I laid out and cut new deals. Say, you know, we want to own the risk, we want to take this on. We want to become parties to the solution. I can taste that as possible at the levels of communities, maybe states. The problem, of course, is that so much money comes from the federal government and we would need a federal architecture which is permissive, which says, OK, go for it, try it.

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That's what ACO's were supposed to be. That's what some of the experiments that CMMI were supposed to be. But we haven't gone far enough. But I would say if in communities, physicians could come together under some sense of vision, we could see some good examples develop that would potentially be convincing. Don't forget, also we have publicly-funded forms of care delivery, federally-qualified community health centers, for example,

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that I think could offer some chance, given more license, which is politically achievable, to really reconfigure care.

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I think the new onset of virtual care offers a lot of potential for everybody to really take a deep breath and say, is there a completely different way to do this? I was on a video conference two days ago with the Primary Care Collaborative (PCC), which three, actually, one group was a group of nurse practitioners in New Hampshire and then two other physician groups, one IORA Health, which is very interesting, and another smaller group. They were talking about truly transformative ways of working with their populations that they always had, but that were catalyzed by the COVID pandemic.

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And I take a lot of hope for these examples of change. In the end, though, I say we're going to need courageous political leaders, people who are going to step out and say we can't do this anymore. Your federal government can't function with this millstone of healthcare costs around its neck. We've got to find a way to solve this. We don't want to be in a country...we're not going to lead a country where poverty generates so much illness and we're waiting for that kind of political leadership.

[00:33:25.710] Don Berwick, MD:

It will come.

[00:33:27.460] Don Crane:

So, we will need strong political leadership to enact laws in Congress, no question. But the federal government right now controls the largest payer or payers in terms of Medicare and Medicaid, and one would think would, even without possibly legislative action, be able to do a lot more in terms of achieving these four aims within your definition of a value.

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I frankly, along with others, I think, Don, you know, wonder, raised this question of, OK, if we experimented enough with, you know, upside-only ACOs and next gen ACOs and so forth, should we not move much, much more assertively to models that have proven successful? And there are many. Kaiser Permanente is a good example, but there are others. IORA is a good example, Village MD, ChenMed, Healthcare Partners, goes on and on.

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These are organizations that I think have attracted the interest of private equity companies because they deliver value and are successful. You know, why do we not simply go ahead and fund some of these best examples and ask them to proliferate? In other words, provide capital to allow them to proliferate? Why do we not, you know, identify exactly what they're doing and use those as the templates that we want to incent. Thoughts on that?

[00:35:01.480] Don Berwick, MD:

It could be done. First of all, what I said earlier, and you're inviting me to, you seem to agree with us. We have, we do have 10 years of ACA experience now with alternative payment. I mean, it's a massive experience and there is a need for dispassionate, nondoctrinal reflection on what actually seems to be working and what doesn't. I'm a little bit…so, I know that the margins for improvement are theoretically massive. I really mean, we're spending about at least a third of our healthcare dollars completely wasted.

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For example, yes, we know there's 300 billion in transaction costs a year that's documented. So, on social determinants and quality, just don't get me going. I'll use the rest of our time. But surely margins were getting great. And I think we have to be a little careful not to over celebrate tiny little gains. You know, this isn't a one percent gain. It's a 15 or 20 percent gain if we play it right and we're celebrating one percent.

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We're asking, is this really one percent or not? I don't…that doesn't turn me on. But there is a chance to reflect on where we got some gains or not. But you're right, there are models out there now. We kind of, you know, they're compartmentalized, they're local, they are fragile, but we kind of know what it would look like to be there. You've mentioned some of the leaders. There are others. There are community, rural communities that have done wonderful things, trying to develop rural community-based health systems, not rural hospitals, rural health systems that I find exciting.

[00:36:42.050]

But we have trouble taking these to scale. And federal government could do that. We have CMMI. CMMI which I got to set up, is a national treasure. I mean, this country was smart enough, even in the midst of this terrible polarization, to set up what could be the NASA of healthcare and really invest in these models. Technically not as a matter of finance or politics, but technically figure out what they look like.

[00:37:12.710]

That's not where CMMI has gone. It needs a reboot. It needs to rethink its role as the catalyst for massive delivery change at a scale convincing enough that we could spread it. So, you're right, things are in place. It could be done. But we need federal leadership that understands those four aims and that is holding itself accountable for their achievements at scale for the country. And it hasn't quite arrived yet. Running CMS, being the CMS administrator, was the thrill of my lifetime. I can't tell you. Oh, my goodness, I got to see the potential. It was like walking into a room and finally seeing endless possibility, an amazing staff. Fifty-five hundred people there who are dedicated to trying to make healthcare work. Databases to die for. Just incredible amounts of information that we could glean. You know, a chance to move at scale so that when something really works, you could take it into regulation or some regulatory guidance. A real sense of mission and duty, transparency, accountability, public, a low transaction cost.

[00:38:27.140]

The problem was that sort of everything we tried to do hit the political stone walls that are all over Washington. And we need to we need to free ourselves somehow from that. You did say one thing I do want to comment on, and this is a little edgy. You mentioned venture capital and private equity and so on. And, yes, we need to be cautious here. You know, the interest to be defended are the interests of health and well-being of the American population.

[00:39:02.090]

I do not any longer believe that a profit motive is a reliable way to pursue that, not under certainly, not at the current circumstances. And as we see private stakeholders enter this field—a door open wide in the Medicare world, and currently a lot of people would like to see it wider—we are going to invite in shorter-term interests and pressures that I think may make things worse rather than better. So, I personally would rather see a public investment in these changes than a private one.

[00:39:41.360]

That's my personal position.

[00:39:42.950] Don Crane:

Well, this is good.

[00:39:43.540]

Let me press. I mean I won't argue back. I mean, we do need to wrap up. So, I think I would ask you, if I may, could you identify, let's say, one or three of perhaps the sort of ideal models if there's such a thing that you would recommend to America? I mean, I'm assuming that there's a number of different ones that all of which could work. But what are your top three or two favorite systems?

[00:40:12.380]

So, payer to providers, financing...what would you recommend?

[00:40:20.930] Don Berwick, MD:

It's a tough question, Don. Partly the answer is contextual. That is the answer for, you know, for the stressed parts of Manhattan might be different from the answer for Omaha or rural Kentucky. I think there are different kinds of models, we have to be smart enough to make sure that the healthcare delivery designs are compatible with local circumstances in history so that there is no one answer in my view. I've mentioned some of the ones that have me very excited.

[00:41:00.390]

You know, I don't want to be politically incorrect at all, but I do say Kaiser Permanente overall, it tends to excite the eye. There are plenty of things I'd change about it. But when I sit down with the Permanente Medical Group or a local Kaiser unit, they're trying, they really are trying to figure out my four aims, I would say. They're under constraint, but it's the advantage of seeing a globally-budgeted system kind of keep in mind its population.

[00:41:29.580]

I wish they would play more directly with the impoverished and disadvantaged communities of our world, but they're trying. You mentioned IORA Health. I think the concept behind IORA is absolutely brilliant and it is much, much closer to the kind of primary care-based, population-oriented, flexible delivery configuration that we really need. And it's a very, very promising model. But payment systems have to

change a lot to make it thrive offshore. Nobody's perfect. I get to visit Sweden quite a bit, or at least when the pandemic's not around.

[00:42:07.380]

Sweden has a very interesting setup. It is a single payer environment, but at the county level or regional level. So, you have regions of maybe 300,000 or 400,000 people and a responsible party holding the budget for the care and well-being of that population and able to move money into sectors that are not normally associated with healthcare, like education or community support systems or supports to the aged. And you see a much more kind of planful, rational configuration of energies and resources to actually move upstream to deal with people's lives where the lives matter.

[00:42:46.920]

Some other countries, for example, Singapore. I'm working with Singapore quite a bit now. You know, that is a much more, sort of a commercial ethos there of competition. But in the end, there is a ministry of health that's thinking about how to deal with massive issues in a country like aging or like the well-being of children or the pandemic. And that you have a sort of…it's like you have a brain.

[00:43:15.960]

You're working with a brain. It doesn't always go perfectly. And I'm not sure...it's certainly a different political environment…but when you have a group of people that can sit with and say, we are responsible for five million lives, we are responsible for the well-being of these eight million people, of these three million people. It changes the game and you can start to really have rational conversations that are very hard to achieve in the American context right now.

[00:43:42.830] Don Crane:

Do you think? Final question, Don, and I'll let you run. Do you think that our disaster with COVID, the pandemic—I guess disaster is the right word—but is this a teachable moment now that creates more opportunity for the kind of scrutiny, thinking and change that we're after? I mean, should we be leveraging off the pandemic, so to speak? We've seen the failure of fee-for-service. We've seen how prospective payment seems to work.

[00:44:10.950]

Is this a, you know, one of those moments that we should really leap forward with greater vigor?

[00:44:19.310] Don Berwick, MD:

Yes, if we're willing to listen and learn. Like you said, it is clearly true that it is the capitated or globally-budgeted physician groups, for example, that are, I mean, they're obviously reeling under this tragedy, but

they're doing OK financially compared to ones that are hooked on the fee-for-service model. We're seeing a much more interdependency.

[00:44:46.010]

We really do depend on each other, which is a key value structure, to solving the problems we've been talking about, Don. The expansion of telemedicine telehealth, I think is a massive leap forward. So, I think, yes, there's a lot to learn if we will reflect. The most important of all, the lesson America has never learned yet and that's solidarity. Only in wartime. We haven't learned how to express solidarity and mutual responsibility and a sense of caring for each other and about each other as a mainstay other than in wartime.

[00:45:18.050]

And right now, you're seeing that play out, of course, in political divides and behaviors. I think we also could learn that the public health infrastructure is key. There is also a chance for mistakes that we could learn the wrong thing. I'll give you an example. The hospitals of today are heroic. My goodness. I mean, my daughter's a hospitalist, and I can't believe the pressures and the intensity that the hospitals are feeling and responding to and doing their best.

[00:45:49.430]

And so, we, of course, correctly, are lauding them and thanking them and try to get them resources. But we will be taking the wrong lesson away if COVID makes us think that we need a hospital-centric health system because we don't…we need the opposite. And so there could be a chance for misunderstanding as well as understanding. But time will tell. Of course, the other issues, equity. I mean, you cannot watch COVID without heartrending reminders of how unjust and inequitable American society is today and of course, the vestiges of slavery and structural racism, all of that.

[00:46:28.800]

Sure, that could be a teachable moment and I hope it will be.

[00:46:32.720]

I agree completely, Don. Thank you so much. We've got a lot of work to do together. Hope we have that opportunity. And I just want to thank you very, very much today and wish you well. Stay safe. Stay healthy. And where we need to wrap up. So, Don, thank you very much.

[00:46:49.460] Don Berwick, MD:

Thank you, Don, for your friendship and leadership as well.

[00:46:51.650]

And let's keep at it.

[00:46:53.390]

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