

Tricia Johnson (00:03):

It's Aspen ideas to go from the Aspen Institute. I'm Tricia Johnson, dr. Zeke Emanuel was an architect of the affordable care act, which turned 10 years old last month with the COVID-19 pandemic. People are losing their jobs and with that their health insurance,

Ezekiel Emanuel (00:20):

You know, if I think about the coronavirus situation, one of the things that is quite clear is that it's filled with uncertainty. And one of the many uncertainties is, you know, how do I maintain coverage?

Tricia Johnson (00:34):

The Trump administration has fought to get rid of the ACA, but with 22 million people unemployed in the U S is the law needed. Now more than ever Aspen ideas to go brings you compelling conversations, hosted by the Aspen Institute. The Institute drives change through dialogue, leadership, and action to help solve the greatest challenges of our time. Today's discussion was held by Aspen ideas. Now a digital content initiative at the Institute, People who never thought they'd be unemployed are out of work and standing in bread lines. Thanks to the coronavirus, bioethicist and oncologist Zeke Emanuel says in this new reality, people want security. One aspect of a secure future is health insurance, especially in a pandemic.

Ezekiel Emanuel (01:19):

It seems to me totally untenable to maintain that we're not going to provide guarantee insurance for everyone in the country, um, and still need people to go into the hospital to get COVID tested and all the other stuff.

Tricia Johnson (01:32):

Today, he speaks with Perri Peltz, a journalist documentary filmmaker and public health advocate. We caught up with them in their home offices to discuss universal coverage, the November election, and what needs to happen for the country to reopen here's pelt

Perri Peltz (01:47):

Dr. Zika manual. Welcome such a pleasure to be able to, to talk with you right. To be here. So let's go back in March. You outlined a plan for containment, which would lead to a soft restart of the economy in June. Here we are mid April. Are we on track for June? And what does, in your opinion, what does recovery look like?

Ezekiel Emanuel (02:13):

Uh, well, first of all, um, to get on track for recovery, we really have to focus on testing. Yeah, there's a certain infrastructure that's going to be necessary for getting people back to work. That infrastructure begins with testing, contact tracing, um, and, uh, protecting, uh, uh, going the extra mile for the most vulnerable people, whether it's the elderly or people with serious comorbidities, mainly around vascular disease. So people with diabetes, with heart disease, um, and, uh, asthma and emphysema obesity, those are at the top of the list. Um, and those three things need to be in place, uh, you know, over the last days, um, there's been, uh, the administration tried to convince everyone that it was more, they'd been doing more than enough testing, uh, where we tested just barely over 1% of the population that

clearly convinced no one. So more recently they're arguing, they're going to invoke the defense production act to get, uh, various shortages South, um, that may help.

Ezekiel Emanuel ([03:23](#)):

Uh, I think they're probably hearing from a lot of, uh, businesses, uh, that if they're going to restart, they're going to have to test people and testing is not available. You know, no one was convinced that they were testing enough people. So I think that's where we're at. Um, and we simply have to test more people if we want to be able to reopen what does reopening look like? Well, I will say that the president's plan at least had this element right in structure, which is you need metrics on which you're going to reopen. You need to have an infrastructure, uh, when you reopen and you're getting it reopened in phases, not all at once. And those phases are going to vary by the kind of business you're running and the kind of distancing you can have. So I think those four elements were right in the plan.

Ezekiel Emanuel ([04:10](#)):

Uh, I think they got some of the details totally wrong. Uh, but I think that's correct. We're going to start phasing in and opening up where the risks are. The least distancing can be maintained the best, um, as well as many of the other things you can wash your hands, you can have face masks, et cetera. And then at the very end, we're going to, uh, open up, uh, where the very end is probably, you know, uh, 18 months from now, we're going to be able to open up larger meetings where distancing isn't so wheezy, et cetera. And that assumes that we have a vaccine input, uh, available

Perri Peltz ([04:47](#)):

18 months. That's a really long time from now. That's, you know, that's a year and a half away. What does it look like between now and then our school's going to reopen? Are we going to be able to people going to go to restaurants? What does life look like?

Ezekiel Emanuel ([05:03](#)):

Yeah. So I think, um, in phase one, as I've advocated, I think schools are probably a really good place to reopen, uh, separating out desks. Um, the, the, the, uh, Danish are trying this right now. So we're, we're going to have the advantage of looking. They're separating out desks. Kids come to class and the come to school in staggered time so that you don't have a big crushing rush. Um, you separate desk by six feet. You have kids wash immediately when they get in, you have them wash every hour. You clean door handles and other items where kids are likely to be touching them a lot. You have kids playing in, uh, during breaks and small groups only. Um, and, uh, you recognize that this has to be balance hearing. Uh, there are some parents in Denmark, understandably, so worried that their kids might get COVID-19 come home, uh, and put the parents at risk.

Ezekiel Emanuel ([06:00](#)):

Uh, and so you have to have this initially on a voluntary basis. Um, same thing with teachers, you initially have to have a non voluntary pay patients because the teachers might be putting themselves at risk. Um, and they are beginning in Denmark with the youngest kids. I'm not sure I would necessarily agree with that, but, uh, it's, uh, uh, seems like a very smart thing to do. I would actually, uh, think that, uh, you can begin anything up to about 21, 22. If you look at the data, there's, I won't say no deaths, but almost no deaths under that group. And, and a very limited number of cases under that group, so that most of those kids seem to be either asymptomatic or not getting it. Um, and, and that's probably a

group I would begin with. Um, and, uh, I think, uh, that would probably be first restaurants where you can keep people, uh, tables more than six feet apart.

Ezekiel Emanuel ([06:59](#)):

Uh, waiters can wear, uh, wait, uh, wait, staff can wear masks and gloves. Um, I think that's, uh, a way to go, whether that turns out to be viable for restaurants to have half the number of customers or something. I think that's a pretty big challenge. Um, you know, and I think then we'll begin opening up to businesses where meetings are, uh, sort of important, uh, as long as you are able to physically distance reduce, um, congestion, uh, test people before, uh, and probably on a periodic basis. Um, so that's how I see it in the very end, as I mentioned, are going to be those venues where it's very hard to get physical distancing, sporting events, um, conferences, uh, concerts, um, you can't really do them. Uh, it's hard to have a sporting event. You know, there's going to be a rush at the entrance. There's going to be, uh, people wanting to go to concession stands, even if you space people out, uh, there's going to be high fives there. Cheers. Um, all of that stuff makes I think sporting events with fans, very unlikely sporting events without fans, I think is a much more viable, uh, option.

Perri Peltz ([08:13](#)):

So you mentioned that testing is pivotal, and yet it seems as in spite of all the talk about testing that we don't have enough testing, do you anticipate that's changing in the immediate future and what do we do without that without adequate testing?

Ezekiel Emanuel ([08:30](#)):

Um, three really good questions. Question number one. Uh, you know, we've just had so many mistakes about testing and every time everyone says we got testing under control, we clearly don't have testing under control. So, uh, going out on a limb where I don't control it and saying, Oh, we're going to have testing. It's going to be here in six weeks where everyone we want to have tested is going to it. I wouldn't say that. I think it's irresponsible to say it. Um, and I would say that the administration on a stop talking about, we got testing under control and prove that they have testing under control, um, rather than say it, because there were on this issue is not good. Uh, as many of the listeners will know that, you know, the FDA reported pretty decisively that the CDC, um, screwed it up as a, probably a gentle word multiple times on their way to getting, uh, test kits out there.

Ezekiel Emanuel ([09:27](#)):

Um, and you know, it's not believable, um, that, uh, everything's under control. Could we get enough testing in the next six to 10 weeks? I think that's probably true. Um, but you know, it depends upon execution. And so far execution has been a Bismal. Um, I think there's no way to sugarcoat it. Uh, and, uh, uh, the administration tried to sugarcoat it, uh, last week didn't work. Um, so I think just fess up, it didn't work. Do we need [inaudible]? The answer is yes. And how much testing while the minimum projections, which I think are wrong are 500,000 tests per day. Uh, my own, uh, sort of minimum is about 2 million tests per day. The 500,000 want to focus on people with symptoms and people with moderate symptoms. Um, that is I think, the wrong approach. So if you want to open up what you have do is control spread.

Ezekiel Emanuel ([10:29](#)):

And if you control, think about controlling spread, who, who tests under those conditions, um, your paradigm changes from testing, people who are symptomatic, right? The testing two main groups, but

there are four real groups. The two main groups group number one is everyone who meets a lot of an intersection with a lot of other people, um, and could spread it to many people. So that's frontline, healthcare workers, grocery workers, policemen, and other first responders. Those are the people that need to be tested on a regular basis. Um, that would be once a week, at least, um, there are about 7 million of those people on a conservative estimate. So that's 7 million tests you need a week, which is a million tests a day. And beyond that, the second major group, although not only group, the second major group are, uh, asymptomatic spreaders. So the people who can really do wreck havoc on a system where you're trying to contain and control the, uh, COVID virus are people who unwittingly have the virus and go about as if they didn't have the virus.

Ezekiel Emanuel ([11:32](#)):

Those are asymptomatic people who don't have any symptoms and could spread the disease. Um, by the way, we've seen it yeah. In other, uh, uh, not pandemics, but other infectious spreads, uh, typhoid areas, a famous person who, a woman who worked in kitchens didn't know that she had and spread it to many, many people in New York. So I think the same thing is true here. You've got to test asymptomatic people. You know, I, I allocated an extra million a day for that, which I think is, uh, is kind of the right number. If you think that somewhere between 25% and maybe as high as 60% of people who get COVID 19 infection are asymptomatic. That 60% number comes from the USS Teddy Roosevelt, where 60% of the sailors who got, who were COVID positive, have no symptoms.

Perri Peltz ([12:25](#)):

Cool. ZQ talk about testing, being critical contact tracing is obviously an important part of that, but comes with lots of challenges, most notably privacy. How are you thinking about contact tracing and explain how you imagine it to be

Ezekiel Emanuel ([12:41](#)):

So look, contact tracing in the old Bay, he was sort like gum shoe operation, uh, someone going out and finding all the people you connected with. We have to use technology today. First of all, the virus is spreading so fast. And second of all, we have the technology, you know, at Facebook clearly knows when you leave your house, who you interact with, and we need to use that technology. We can't trust Facebook point blank. So we'd have to be able to give that data to some independent organization, uh, and under two very, very important conditions, important condition. Number one. Now we're going to commercialize that data, not going to share it with anyone else and important condition. Number two, the data gets destroyed, non merged. We're not talking about, we keep a shadow. Part of it destroyed every 45 days. The, the data from, uh, gets destroyed from the previous that's 45 days old, um, because it's no longer relevant and you need to junk it.

Ezekiel Emanuel ([13:46](#)):

Um, I think that's going to be essential. Are we giving up privacy? Well, if we give it to a trusted organization that isn't commercializing it, that isn't merging it with other personal information, and that destroys the data. I don't think in any long-term basis, we're giving anything valuable up. Um, is that a risk that, uh, some players might not play ball Facebook might not play ball. We already give them a lot of data that we don't realize in a lot of power over our data, and they need to be better players, uh, in this game. And I don't think big tech has stepped up in the way it should to help fight this. Uh, now maybe they're just worried, but I think, uh, if they're worried that just the test of how little, how

untrustworthy we think they are. Um, so I think, you know, contact tracing needs to be done and it needs to be done in a high-tech way.

Perri Peltz ([14:36](#)):

So let's go from, if we think about testing as sugarcoating, let's just move to confusion. And that is certainty. We know is that millions of Americans have lost their jobs. And with that, we lose their health insurance, the affordable act, which you designed would have allowed those people to get that coverage. Here's the confusion. The administration is trying to get rid of the ACA and yet it's telling people they can still sign up for insurance. Can you help us make sense of all of this?

Ezekiel Emanuel ([15:07](#)):

No, it's a contradiction. It's a contradiction in terms. Look, I think one of the things that's going to clearly, you know, if I think about, uh, the coronavirus situation, one of the things that is quite clear is that, um, it's filled with uncertainty and one of the many uncertainties is, you know, how do I maintain coverage? 22 million people have lost their jobs. They're going to lose their health insurance pretty soon. And, uh, you know, they're not going to be happy about that. They could either die into the exchange if their income is high enough or they could get Medicaid, uh, if their income's low enough, except of course in those 14 States that have decided they're not expanding Medicaid, um, it's a, it seems to me totally untenable to maintain that, uh, we're not going to provide guarantee insurance for everyone in the country, um, and still need people to go into the hospital to get COVID tested and all the other stuff, if it's necessary, or if God forbid that it gets sick from COVID, uh, not to go into the hospital because they can't afford it.

Ezekiel Emanuel ([16:13](#)):

Um, we need those people to take care of themselves so that they don't spread it around. Um, so I think one of the things you're going to see coming out of, um, the situation is, uh, some renewed effort to get universal coverage. And I think, you know, not just universal coverage, one of the things we're also saying is, you know, a lot of people are unemployed who never thought they'd be unemployed or having to be in red lines who never thought they would have to get free food. We're going to have to bolster the food stamp system. Another thing we obviously have to bolster is the whole system related to unemployment. We've got this artificial, you're on unemployment for a certain amount of time. Why are we, you know, business cycles don't respect 13 weeks, 26 weeks, whatever the period of time is, right. We should have unemployment to the change in the business cycle. I think you're going to see a lot of changes, uh, to shore up the safety net because people want security.

Perri Peltz ([17:19](#)):

So here we are, it's the 10th year anniversary, correct. Of the affordable care act.

Ezekiel Emanuel ([17:23](#)):

Yeah. It was just almost precisely a month ago.

Perri Peltz ([17:26](#)):

Well, here we are at an incredible moment, um, at the 10th year anniversary. And I'm curious how it, what's your thinking right now about the affordable care act and universal healthcare coverage. You just mentioned universal coverage. What's where where's your mind at on that?

Ezekiel Emanuel ([17:44](#)):

Uh, we clearly, you know, the ACA made a good dent got 22 million or so people coverage. Uh, we made a good dent, I think, on cost control. Um, but it was, you know, it didn't fix the system. Um, if anything, I do think one of the things we can be criticized for is that we made it a little more complex adding into an already complex system, the exchanges, um, I'm all for that because America, we seem to make things complex to get everyone in by, you know, a patchwork system. I think one of the things you're hearing, we heard from people immediately before, uh, this coronavirus crisis are two things. One systems too complex. We need help navigating it, simplify it for us. And to more importantly is, you know what, it's too expensive on a four it's unaffordable affordability became the watchword and getting costs under control vital. Um, I don't think we can forget that as we proceed to, uh, try to shore up the system to bail out hospitals and doctors. Um, we do have to think about, well, if we're bailing them out now, how are we going to be sure that the system doesn't simply go back to explosive cost growth,

Perri Peltz ([19:01](#)):

Right. Well, which is such a great point because as you speak about the rise of telemedicine, telemedicine is something that we as Americans have largely resisted. And now we see it works. It seems as though it's an argument that there's something to be gained at this particular moment in time as we go through this pandemic. Tell us a little bit about how, how your thinking about that this actually can be a moment to fix. So

Ezekiel Emanuel ([19:28](#)):

I would say, as I mentioned, I think three of the sort of delivery system changes that have been good are more telemedicine, uh, uh, less elective procedures and higher threshold for hospitalization. So I think we need to expand telemedicine. Probably the most important thing we can do going forward is we know that a lot of doctors are hurting now, especially independent doctors who are not affiliated with hospitals and health systems. Um, and those are important. Uh they're they deliver care, uh, that's lower costs, uh, in the system. We need them and we need to help them. It it's a perfect opportunity for us to switch payment to those doctors off of fee for service and to, uh, alternative payment models where they're sensitive to the quality of care they give and sensitive to the total cost of care, uh, that they're ordering. And I think that is very important, uh, change going forward. Um, and I think it's, uh, it's one I'm working on to try to facilitate. Um, and I think it could be a perfect opportunity for many, uh, um, uh, payers to help doctors transition to a capitated environment. And I think doctors would be receptive in a capitated. They would get paid. And if they handled most of their patients' care by telemedicine, they'd be paid the same.

Perri Peltz ([20:54](#)):

So if we don't implement these policies that you're speaking of to maintain these changes, how will America's healthcare system be actually worse than it was before?

Ezekiel Emanuel ([21:05](#)):

Because prices will go up again. They'll just keep going up because we will have done nothing to, um, we'll just have spent hundreds of billions of dollars shoring up hospitals and other parts of the healthcare system, and we'll have done nothing to make them change for that kind of money. And I think that's a mistake.

Perri Peltz ([21:23](#)):

Let's back up a little bit, if we can, as we think about recovery, the assumption is that for those of us who have been lucky enough to shelter at home work from home, we understand that we are, as we start to return to a world where taking on a certain amount of risk, how do you think about risk at this particular moment? Assuming that let's say the best case scenario of vaccine is 18 months down, down the road. That sounds even optimistic at its face. How are you thinking about, um, this plan to end this crisis?

Ezekiel Emanuel ([21:58](#)):

I think that's a great question, which at its heart, we all have to recognize life has risks. There's nothing we do in life that doesn't have risks. You know, I remind, I used to get calls when there were infections in China or Hong Kong or issues, you know, um, in part, because I'm the vice provost for global initiatives and we send students overseas. So people think, you know, he's got some understanding of what the risks are in various countries. Cause he's sending students there and they would say, should I go? And I would say, how are you getting to the airport? Oh, I'm driving to the airport. What are you asking? I said, okay, that's the riskiest thing you're doing? You know, um, I used to go to, you know, India and Israel and the riskiest thing I did is get in the car once I landed.

Ezekiel Emanuel ([22:43](#)):

Um, and so we have to recognize every part of life has risks driving. I'm a big bicyclist, bicycle. Bicycling has risks. Um, swimming has risks. And so we need to understand that we are going to have that accept some risks related to COVID. And the real question for us is how do we minimize those risks? We're not going to get rid of them until we get a vaccine. And even then a vaccine may not be a hundred percent effective. How are we going to minimize them? And what do we need to do? How much risk are we willing to take on in exchange for reopening the economy? You know, and I think as a society, we haven't wrestled with that yet. And we haven't wrestled with, you know, the fact that the risks are not evenly distributed and since society let's face it, people over 70 have a lot higher risk people with co-morbidities have a lot higher risks.

Ezekiel Emanuel ([23:33](#)):

So we're going to have to have this conversation. And I don't know that we've done. I know that we haven't done actually better to say it that way we have not done the was okay if we increase people's risks, this amount, here's what the economic benefit will be. Here's what the health, how, how much more, uh, people, uh, unfortunately dying from COVID likely to get. And does that seem like the right trade-off and that we, we, that's a conversation we're really going to have to begin to have and not just stumble our way into it. And I don't think, you know, it's not like the United States is unique. I don't think any countries had that conversation because no one has produced that kind of trade off understanding. And I think we have to happen.

Perri Peltz ([24:18](#)):

So let's talk about a vaccine for a moment, because again, it seems to be one of these areas where there's a lot of confusion. Sometimes you hear that we have never moved as quickly as we have to a vaccine for a vaccine, same question for therapeutic interventions. And yet another group that says the fastest we've ever produced a vaccine was four years. So what do you think is realistic because you're right. This sort of comes to a, makes a big change when we have a vaccine, right. That when you really start to see something that looks like recovery and all, it's really

Ezekiel Emanuel ([24:54](#)):

It's back to normalcy if we have an effective vaccine. Um, yeah. So, um, I, unfortunately I'll be just blunt. I, I vacillate between optimistic and pessimistic and I can't tell you what swings me. Um, but so I I'm, the, uh, optimistic side is we've got many, many super smart people working on it. We've got many more platforms to try RNA, uh, vaccines, DNA vaccines, uh, um, cold virus with RNA placed in that, uh, whole, uh, inactivated virus, vaccines, live attenuated virus vaccines. Um, and we've got a lot of big, a lot of experience companies and a lot of, uh, ingenious startups, all working. So that's the optimistic. Um, and I think we're also recognizing we can probably get into Hume now, probably we're already in human testing, but we can get into human testing fast. We can assess the safety relatively quickly and then quickly move to a phase three test, which assesses the effectiveness of these vaccines.

Ezekiel Emanuel ([25:58](#)):

And let me say it is not as if these kinds of vaccines don't have serious risks. They do have serious risks, especially the risk of what's called antibody dependent enhancement of the virus where you give a vaccine and then it actually makes the disease worse. It brings more virus into say the lungs and activating the immune system for more damage. Um, so there are some serious risks and we have to assess for them. Nonetheless, having said that we're not likely to get into, um, phase three testing. First of all, phase one testing really for safety modernists started it already, but seriously, it's like late summer, early fall. Um, and we're going to have to test 2000 people looking for both safety, but also are they producing antibodies to the virus? Then we have to test, are those antibodies effective? Which means do they actually prevent people from getting the, uh, infection?

Ezekiel Emanuel ([26:55](#)):

Um, and that's going to be a bigger trial, uh, probably, uh, Johnson and Johnson has been talking about 12,000 to 20,000 people. So those are pretty substantial size trials and you have to, you know, make a pretty good assessment. Um, that means we're unlikely to get a vaccine out there before, you know, two to three 2021. Um, and that also means taking a risk of if you can get to the phase three tests for effectiveness, beginning to produce the vaccine, even though you don't know it's actually going to be effective. So I think that's the optimal scenario. And I should say a lot of these new platforms, the DNA RNA platform, we've never produced a vaccine against viruses successfully from them. Doesn't mean this isn't the case, but it does mean hold your curb, your enthusiasm. I think someone told me, um, let's be a little prudent before we bet the farm that it's going to happen. Um, so I, that that's that, that's my thinking about this and reason to be pessimistic is, is what you said. The fastest we ever got effect seen is four years. Um, even if we cut that in half, it's still two years, that's 24 months, not 18 every month is more people dying. I mean, you know, there's a reason to be cautious and not, not assume, assume that everything is going to be hunky-dory even in 18 months. So,

Perri Peltz ([28:25](#)):

And are you, are you any more, uh, bullish when it comes to therapeutic interventions?

Ezekiel Emanuel ([28:32](#)):

No. If anything, a little less bullish, really? Um, yeah, because so all the therapeutics we're trying today, the run this severe, the, um, uh, hydroxy, chloroquine, um, all of them are things we've taken off the shelf that we're trying, uh, that were developed for other diseases that we're trying to use in the context of COVID. Now that works. Sometimes we have had a safe solidimide developed for one condition. It really works in cancer. We had Biafra, which we were developing Pfizer, was developing for blood

pressure. It works in erectile dysfunction. Well, for them, it did well, but it's not the usual where you try to develop a drug for X and it really is effective in Y that doesn't typically doesn't happen. So that's the first point. So what we're really going to need is drugs developed for Corona virus to work in can rotavirus.

Ezekiel Emanuel ([29:32](#)):

The second thing is that in a lot of situations like HIV, like hepatitis C, like, uh, cancer, where I practice, um, you need multiple drug regimens, a single drug tends not to be in good enough and because the viruses or cancer cells tend to become resistant to them. So then you say, well for an effective treatment, we're going to need multiple drugs against Corona virus. How we get, how long is it going to be to test multiple drugs? And that's why I become even more pessimistic about getting an effective treatment for coronavirus. Yes, we might find one drug in, it might be moderately successful or effective, but I don't think it will be the idea of a magic bullet I think is, is wrong.

Perri Peltz ([30:20](#)):

Let's go, let's talk about healthcare politics for a moment. If we can. Uh, we are obviously in an, in an election year, you have said that Medicare for all obviously seems to be attractive because of the security that people are looking for. Right.

Ezekiel Emanuel ([30:34](#)):

I say Medicare for all, you didn't hear me use that phrase. I said, providing coverage for everyone there, variety of ways you can do it. Medicare for all is not the only way.

Perri Peltz ([30:42](#)):

Okay. So how do you think this all impacts the, the presidential election?

Ezekiel Emanuel ([30:48](#)):

Um, well, I think what we've seen is that people are having faith in government. Once again, they really want the government to do something and they recognize that having a competent government is good. Um, I think if this, if, if we're in roughly the same state we are today in November, and there's not too much, um, voter suppression and other shenanigans, um, w I think the Democrats are gonna win. I don't think there's any question about it. Um, I don't think the administration has shown itself very competent in battling this crisis. And I think, um, you know, 22 million people unemployed within a month tells you a lot. And I think as much as you want to sugarcoat it, as much as, uh, people want to blame, uh, uh, other countries, other groups, Obama, people recognize we were warned in January. We didn't take it seriously.

Ezekiel Emanuel ([31:44](#)):

Um, we didn't prepare, uh, there were multiple attempts to play it down, and I think that's, doesn't speak competence to people. Um, and I think if, if you think this election is about suburban women and, you know, a sort of broad categorization of people, um, who are the swings here, you know, what do they care about the most protecting their children as their children and stunts of schools in terms of health, um, in terms of livelihood, in terms of food security, have they been protected? I think they're really upset their home. Maybe they're learning online, but probably not as effectively as if they were in the classroom. And I think that's just not a good place. And if we can't start with school and fall and I'm

skeptical that that we're going to be rushing there. Um, I, I, I don't know. I just don't see how this plays well. So, and typically, you know, the party of government under the Democrats, not Republicans,

Perri Peltz ([32:51](#)):

Right? Well, and before the pandemic, before the novel Corona virus came to the United States, we all already knew about racial wide disparities when it comes to, to healthcare. Absolutely not new breast cancer, prostate cancer, you name it, but healthcare. Exactly. And it seems especially bad right now, uh, with COVID-19 the African-American community seems incredibly vulnerable right now. Um, talk to us a little bit about that and how can you even begin to wrap your head around a way that we can fix this incredible inequity that exists in this country?

Ezekiel Emanuel ([33:31](#)):

So there are, um, three things I think to focus. First of all, there are some health conditions that seem much more prevalent in the African-American community, not seeing are more prevalent in the African-American community that are comorbidities that predispose you to a very scary getting COVID 19 seriously, right, diabetes higher than the African-American obesity, hypertension. These are conditions that we know are associated with bad outcomes from COVID-19 more prevalent in the African-American community. Second, we know that there are disparities in access to high quality care that the facilities are not there. We have to do a better job, how we do a better job. You know, I've made various proposals around getting doctors to serve these people, these communities more, how do we do that? Well, you can sort of have, uh, education that subsidized. If people go work in low, uh, in areas that don't have a lot of physicians or nurses, inner cities, rural areas, I think paying for people to go to a medical school and forgive their loans if they go and serve in these underserved areas and in underserved, uh, um, activities like primary care, like psychiatry, like pediatric specialties, um, I think that'll help bring a lot of talent to the community.

Ezekiel Emanuel ([35:00](#)):

And the last thing I think we re need to recognize is public health is critical here. Um, you know, uh, this isn't all about healthcare. It's about eating, right exercising, not smoking. It's about the kinds of investment that people make when they see the long-term and positive future. And we have to get more of that into the community. One of the studies I did, I dunno, it's published about four, six, eight months ago. Something like that was, we looked at those communities where the difference in life expectancy is narrow, where between high income and low income people. And it turns out that the only thing we found that actually make narrows that gap is communities that have high social mobility, where people from the bottom socioeconomic status can imagine that they will climb up and into the top. And we have to return America to a land of opportunity where people can imagine that they will actually have a real possibilities of increasing their income above what their parents earn.

Ezekiel Emanuel ([36:13](#)):

And I think thinking about the policies that we need to put in place for increasing social mobility, uh, especially among minority communities, is going to be really important. Top of my list is early childhood interventions. We know they make a huge difference for educational attainment, staying out of the criminal justice system and long-term economic returns. So that's one kind of program that I think would be very effective. It will take a long time to work through the system and make a big difference, but it's also the program we know has the highest returns for every dollar that the government spends on these

kinds of programs. The returns are seven to \$15, which is a great investment. And we just need to do that.

Perri Peltz ([36:55](#)):

Talk to us about your new podcast. It's called making the call. Why did a very busy guy decide to get into, uh, into the podcast game?

Ezekiel Emanuel ([37:08](#)):

Uh, um, opportunities I will say, you know, in, um, uh, late February, early March, I finished my latest book, uh, which will be coming out in June called, uh, which country has the world's best healthcare. And it was funny. I was talking to my partner, I was talking to my research assistants about, you know, what, what's the next thing we're going to do. And then COVID 19 blew up. And, um, we realized that a lot of the issues were the intersection between health policy and bioethics, which is exactly the place I've made my career. Um, and a lot of people were asking questions about, you know, we're talking about rationing, we're talking about, uh, issues related to quarantine, to isolation, um, issues related to disparities issues related to bringing more mental health things that I've been working on and, and really thinking about for years, you know, it's like, uh, let's do a podcast

Perri Peltz ([38:04](#)):

Realize now more than ever just how important good communication is around public health matters. So thank you for the work that you're doing with your podcast. And as we think about wrapping up our conversation, I'm curious as a physician, as somebody who thinks about the larger public health issues, what's been your biggest surprise about COVID-19 since you started looking at it,

Ezekiel Emanuel ([38:29](#)):

Uh, how devastating it is. I don't think, um, I, uh, at the start really appreciated how bad it could be, frankly. Um, I remember, um, looking at it and I was like, Oh, all right, maybe we'll get, you know, it'll be add on to influenza, but some of the people might have, unfortunately died of influenza will die of COVID. Um, we'll get it contained. Um, uh, but you know, th the, I hadn't thought about it as the big pandemic. Um, I began thinking about pandemics in 2005 when, uh, the department of health and human services released its uh, pandemic preparedness report, uh, secretary of HHS, Mike Levitt, uh, commissioned that report and they talked about how to prioritize people for vaccines and ventilators and other things should an influenza pandemic occur. And I, they got it wrong. I knew they got it wrong. So I wrote my first big paper on pandemics arguing that their allocation procedure was wrong to their credit.

Ezekiel Emanuel ([39:36](#)):

They then had a group think about it, but also interviewed the public and the public agreed with the proposals we made about, you know, prioritizing kids ahead of, uh, elderly adults with comorbidities, if a pandemic comes. And then I've spent really the last 15 years thinking about preparation for pandemics and the ethical issues that go into it. And, um, uh, I taught a course at Penn. I've taught a course at Penn called rationing and resource allocation where some of the big issues revolve around preparing for a pandemic and the rationing that would have to occur and how you plan for it. And I used to say, I have this one slide that looks at the influenza pandemics of the 20th century. I said, you know, there's 1918, there's 1957, there's 1968. And I used to have this throwaway line we're overdue for the next pandemic, um, because they seem to occur every 33 years or so, just spacing them out.

Ezekiel Emanuel ([40:32](#)):

And, you know, w w we were supposed to have another one, but I didn't think it was going to happen in my lifetime. And I didn't think it would happen not by an influenza pandemic. That's what I was prepared for, but for, from a totally different unexpected area, uh, Corona virus. Um, so I think that's been the most surprising thing to me, and also how this virus, you know, very infective, right, uh, much higher are not than, uh, than influenza much more deadly. Now, maybe it's not 1%, maybe it's 0.6%. It's still higher death rate than, than, um, uh, influenza. But then also this sort of very funny, peculiar inexplicable infection paradigm, where it seems like people under 30, certainly under nine, under 20 are seem not to have any consequence from it. But older people are very, very, uh, um, adversely affected much, much higher rates, uh, 15 times, 20 times, 30 times death rate of younger people. So it's like, it's nothing that would have been predicted. And I think very, very, uh, it, it's the thing that has surprised me the most and, you know, let's face it. The biology of this thing is something we still have, don't understand hardly at all, how the body responds, why the immune system seems to over respond, which parts of the immune system over respond. Um, it's, it's very, very strange.

Perri Peltz ([42:01](#)):

You share the one piece of wisdom that you would like our listeners to walk away with after they finished listening to this podcast.

Ezekiel Emanuel ([42:09](#)):

So I remember that, um, Peter Orszag when he was head of office of management and budget, and I was working for, uh, him, um, used to heavily emphasize to our staff meetings. You know, we've got to think about situations that have a very low profitability, but a huge magnitude of impact if they happen. And we should think about them and try to see what we can do to plan for them. What COVID certainly has said to me is these low probability, but high impact events are ones we need to pay attention to a lot more and plan for it a lot more. It's hard to plan. It's hard to justify paying, although all of us buy insurance for the low probability of fire in our house, uh, which has a huge impact, right? So we already do it in our personal lives, but I think as collectivity as a country, we need to, as a world, we need to do a lot more worrying and thinking about these low probability high impact events.

Perri Peltz ([43:05](#)):

I think on that note, dr. Z Kyla manual, thank you so much. And thank you for the truly important work that you and your colleagues are doing, uh, to try to help navigate our country. If not the world through this global pandemic. Thank you so much. Stay healthy.

Ezekiel Emanuel ([43:22](#)):

Thank you. Really appreciate it. Take care.

Tricia Johnson ([43:31](#)):

Zeke Emanuel is the former Obama white house health policy advisor. He's the co-host of the podcast, making the call Perry Peltz co-directed and produced the 2019 HBO documentary alternate ending six ways to die in America. Their conversation was held April 20th. Make sure to subscribe to Aspen ideas to go wherever you listen to podcasts, follow Aspen ideas year round on Twitter and Facebook at Aspen ideas, today's show was produced by Marcy Criven and me and recorded by the Aspen ideas. Now team at the Aspen Institute, our music is by Wanderly I'm Trisha Johnson. Thanks for joining me.

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