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MIND, BODY & SOUL Part IV:
Innovative Models and Technologies to Reduce Health Disparities

Building a More Equitable Health System for All

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Max Gomez, PhD:

The symposium around building a more equitable health system for all will be moderated by Dr. David Nash, founding dean emeritus of Jefferson College of Population Health.

David B. Nash, MD:

Well, it's so great to be here for the first virtual, but the fifth annual International Vatican Conference. And I'm here with some outstanding friends from all around the world. What a great opportunity. My only wish is that we could all be physically together, but next time we'll be in Rome together. So, I'm here today with Dr. Paul Farmer of Partners in Health, Dr. Walter Ricciardi of the World Federation of Public Health Associations, and Dr. Chelsea Clinton of the Clinton Foundation. Welcome colleagues. Great to have you with me. Our topic today couldn't be more timely, right? Building a more equitable health system for all. My goodness, what the world has been through in the past year and a half almost. And what's happening right now in different parts of the globe, I couldn't think of a better team to put together for this amazing meeting to tackle how do we build a more equitable health care system.

So let me start with Paul Farmer. Paul, you have been all over the world multiple times. Your work with AIDS, your work in Haiti, your work in Sierra Leone. My goodness. So, if you had to distill some of the take home messages for our global audience, even from your most

recent trip, as it relates to building a more equitable system, what would you advise our colleagues from around the world?

Paul Farmer, MD, PhD:

Well, first of all, thank thanks so much for letting me be part of this David and all of you who organized this. I just got back from Sierra Leone, and I'm still in transit. And I just want to give that as an example of lessons learned, hard lessons. I never set foot in the place until 2014 when it became clear there was a major Ebola epidemic. And one for which that region was uniquely ill prepared. They didn't have the staff they needed after the war, the civil war. A lot of people don't know about the blood diamond war. Didn't have the stuff they needed such as supplies, they didn't have the space. A lot of hospitals and clinics had been destroyed during the war. They didn't have the systems. And so too was the case in Liberia to a lesser but important extent in Guinea.

So that region had to learn the hard way about things like social distancing, mask wearing, contact precautions, PPE, and later how to roll out a vaccine. So, I think a lot of the lessons that we've learned in some of these settings, it seems so different from Italy or the United States are important ones. And when you think about Rwanda and what it's managed, then you can find a lot of very good lessons, not just for Sierra Leone and Liberia, but also for the United States. And I'm sure Chelsea and others will have something to say about those lessons as well.

David B. Nash, MD:

Great. And we're going to come back to your experience as well, Paul. Thank you so much. Well, Walter, great to see you. Great to be together. My goodness, Italy has been sort of the test bed for the whole world, what you went through a year ago now, how you've recovered. So, I guess it's a similar question that I asked Paul, can you distill for our global audience, what were some of the take home messages that you and your colleagues learned and through the suffering that Italy just recently went through?

Walter Ricciardi, MD:

Yeah, we had to take very tough decision in a short time. I cannot forget when we invited all the ministers of health of the neighboring countries in Rome to explain that we were going to lock down the country. So, for the first time in the modern history, that an entire country of 60 million people was locked down for two months. And this decision that I still remember the face, they couldn't believe it. And they say they immediately told that they were going to do the same in their own country. And at that time was unimaginable, but that was a decision that we took to protect the south. Because as you may remember, the epidemic started in the north, which is much richer and much better equipped and was a disaster. We couldn't imagine if the epidemics could strike the south of Italy. And in fact, afterwards, this decision saves approximately 40,000 lives in the south. So that was really, really difficult to take this decision.

Unfortunately, I must say that the lesson was not learned, because whenever summer came, everybody forgot it. And they try to reopen it, everything, and the second wave strike and the third wave strike, and now all the country. Now, of course, we have to protect the

poor. In a country like Italy, where we have a national service, it's not a problem of geographical distribution is a problem of socioeconomic and geographical, and we have to manage like this. And I hope that in the future, we take a memory of this lesson.

David B. Nash, MD:

Wow. Well, I hope we'll be able to draw on that globally, Walter. And we'll come back to about some of the additional lessons, and I can't help but mention this special relationship between Jefferson Health in Philadelphia and your amazing organization in Rome. You served as an early warning system for our physicians who were in touch with you Christmas time a year ago. And they said, be careful, here's what's coming. We were lucky to have your help and something I know that my clinical colleagues will always be grateful for. Well, speaking of grateful, amazing to have Chelsea Clinton here. Thank you too for joining us, the work of the Clinton Foundation. So, you're probably the best person to address these public private partnerships. What do you see the role of the foundation and the learnings that you've been able to garner from this dreadful year we've all had?

Chelsea Clinton, DPhil, MPH:

Well, thank you, David. And thank you to the Vatican for convening us virtually. I want to acknowledge that this still is very much an awful time, that so much of the world is living through. And I think it is important that we recognize that we are still very much in this together. Albeit while here in the United States, we continue to vaccinate on average about three million people a day. Our experience at home is diverging rather rapidly from so much of what the world is continuing to endure. And that not only do we have a responsibility, I think, a moral urgency to try to help alleviate suffering around the world, it also very much is in our own economic security and public health self-interest.

And so, just your question about public-private partnerships. My father started the Clinton Foundation 20 years ago, really in reaction to another yawning, growing and indefensible health inequity, that HIV positive people here in the United States and Italy and much of the Western wealthier world were able to access lifesaving medicines and so much of the world who weren't in those wealthier geographies were not able to. And so he started the foundation to really change the antiretroviral market from one that was a high-price, low-volume dynamic to a high-volume, low-price dynamic. And we proved, as Paul had been saying for many years, even by that point two decades ago, that when people have access to medicines that will save their lives, they will take them. There will be good adherence. People want to live. People want to be able to be there for their children, their grandchildren. People want to be able to work and to thrive.

And so I find it quite painful, David, at this moment that there is this posture of "Ugh." Well, if we have trips waivers, which are important to help democratize and unlock access to the mRNA technologies that we know have been so powerful for the COVID-19 vaccines, like if we do that, vaccine manufacturers won't be able to make them, or if we do it, how do we know that they'll be able to be distributed? Or if they're distributed, how do we know people are going to line up to take them? Well, we know because we've been to this dance before. And so right now, to your question of public private partnerships, I think we have an urgent, urgent need for the largest public private partnerships that we would have ever seen across the globe to really rapidly scale up vaccine manufacturing and distribution around the world,

because it's just inexcusable that we aren't already doing everything that we know could work to be able to do that.

David B. Nash, MD:

Well, so heartfelt, Chelsea, and as we're here today, of course, what's going on in India and in Brazil. And of course, this group embraces the fact that we're only going to be safe here when we're safe everywhere. And that is the key message. And we'll come back to you more and talk about misinformation and what's limiting vaccination, I mean, incredible. And we appreciate, of course at this conference that 16% of the world's population owns more than half of all the doses. So, a very small percentage of the globe's total population is driving all the ownership. And we can talk a lot about reducing hoarding, reducing the limits on the patents. I mean, there are things that definitely can be done. Well, Paul, back to you. So again, in your experience, let's talk about Rwanda. Are there specific references and specific stories that you we can message better, especially given the current crisis?

Paul Farmer, MD, PhD:

Well, first of all, that's exactly the place that was on my mind as we were speaking. Since we've been summoned by the Vatican and I have to admit, I get a personal charge out of that being Catholic. I just want to go to some language that wasn't really used in Rwanda but is rooted in Catholic theology and Catholic social teachings. And that's the idea of a preferential option for the poor. In other words, I'm not a theologian, but the idea of being God loves everybody and is fully capable of it, but particularly the poor. And pathogens and pathogenic forces, pathogens like COVID, pathogens like Ebola, pathogenic forces like racism, gender inequality, they also make a preferential option for poor. So I don't ... we in medicine in public health say, "Yeah, we're here for everybody, but we're particularly there for them." And what the Rwandans did was not to use that language, which really emerged largely from Catholics and Latin America. And I hope to see it taken up everywhere.

Certainly, Francis has embraced it, but what the language they used was right out of development economics. And they said, "We're going to focus on the bottom quintile." That means the poorest fifth, and we're going to focus on the rural over the urban and the widow and the child and the genocide survivor. And so this language was different and well suited. Chelsea has been there quite a bit as well and worked with the Rwandan authorities as have I for many years, but the effect was the same. That is by focusing on the most vulnerable, all of the roll outs for everything from AIDS treatment, tuberculosis detection and treatment, treatment of stunting, a number of initiatives that were rolled out through the public care delivery system, they were targeted on those who would benefit the most, which are the most vulnerable.

And I think that's a lesson that we need right now. I know we'll get into the question of vaccine hesitancy, which is a very complex issue and not a simple one, but when you're visibly serving, certainly as a clinician, when you're visibly serving those in greatest need, they may be the sickest, they may be the poorest, but somehow they're the most vulnerable, that generates trust. And I think that's what you'd see in Rwanda is a great deal of trust in the public health care delivery system that we sorely need in the United States. I don't know about Italy, but in many places in the world, it would be great to have that kind of trust.

David B. Nash, MD:

Well, Paul, your experience from Rwanda has direct application to the great city of Philadelphia, right? Where one quarter of our population lives in poverty and a city with five academic medical centers, we still do not such a great job of reaching out to the communities that need us the most, because our system is focused on health care service, not on improving health. And so what a great example you've set, and we could bring those lessons from Rwanda right to Philadelphia. No question about that. Well, Walter, back to you, I know that you've also led through your global work with the Federation of Public Health Associations all over the world. And we were supposed to be together in October in Rome, the use of big data. Could you tell us a little bit more about that, especially in the Italian experience? As you were tracking the progress of the pandemic, how did you and your colleagues organize the data, share the data and are there lessons that we could learn from organizing that big data?

Walter Ricciardi, MD:

I think that, and the pandemic has confirmed this, having good doctors is of course the most important prerequisite. I mean, human resources are really important, but management has become important as well, because the organization of health care is so complex. And the pandemics has put in danger millions of, for instance, oncological patients. I mean, only in Italy, we have lost two millions visits, oncological visits and three millions of oncological screening. So, this means that we have to catch up. And to catch up, of course, it's very important that you base your decision on data, on solid evidence. And with this, you can help to target the precise part of the population that needs more. With this, you can target the prioritization of resources. With this, you can take the decision that do not harm substantial part of the population, privileging the one that are needing most so essentially, but for this, we haven't enough data and moreover, we haven't enough expertise.

Now, essentially it's very difficult because when we speak about big data, we speak about millions and millions of data. And this is not very easy to do. And in Europe is also particularly difficult because of the attitude of member states to protect, which of course is very important, the privacy of people. So, you have to find a new balance. And now in Europe, there is a big discussion on this. So, reforming the protection data regulations in order to do that. I think we are just at the beginning of a new journey in which we will regularly use big data for taking our decisions.

David B. Nash, MD:

Wow. And I hope we'll be able to share that worldwide, right? That would be a great outcome from this. If we could learn and share that data and our experiences in the US with yours, Rwanda and everywhere, that's obviously very, very important. Well, and also, Walter, I think you brought up an important point. We have clinicians who have coined the term, “the pandidn't,” meaning the people who didn't get care, who needed it. And at Jefferson Health, our 14 hospitals, we're seeing unbelievable backlog and folks who have missed all of their preventative care. And we're really encouraging people to get back to it because that's actually how you start to improve health. It's incredible. Well, Chelsea, back to you.

Chelsea Clinton, DPhil, MPH:

And David, I should say, I also don't want to lose the focus on children's ... well-child visits as well. And I don't know what is in Italy, but here in the United States, it's just not hyperbole to say that actually tens of millions of well-child visits were skipped or lost, whatever the most appropriate framing is over the last 14 months. And so we also need to focus on a class that is especially vulnerable, our kids. We're catching up kids too, to get their routine inoculations, to get their routine blood level screenings and just so much else. So I didn't want to ... I'm sorry for interrupting, but I didn't want to miss including kids in the really, I think, helpful framing of [crosstalk 00:18:28]

David B. Nash, MD:

Really great point and right. All the talk about vaccinations, we can't overlook the critical ones that are also central to getting back to opening school, right? Really, really important. Well, Chelsea, earlier we just touched on the notion of vaccine misinformation, vaccine lack of confidence, vaccine hesitancy. I mean, what's happening at the Clinton Foundation? How are you helping to focus on the fact that still millions of Americans, millions of educated folks still don't want to get a vaccine? Something that is so vexing to a group like this. Can you shed some light on that for us?

Chelsea Clinton, DPhil, MPH:

Yeah. Thank you, David. I mean, we are doing a lot to try to help both ameliorate and respond to hesitancy as well as to help reach out to people who are currently in vaccine refusal. And I do think it's important to dis-aggregate those groups. So, there's people who are hesitant because they have lots of questions about the speed at which these vaccines were apparently developed. And so, they're worried were steps skipped, questions about what's gone into the vaccines, do we really have confidence and the integrity of the ingredients? Admittedly, also some conspiracy theories around are there microchips embedded in the vaccines, is this some plan for the government to ... or some other authority to track individuals? And so, there are those sorts of questions, which I think are very much on a spectrum and yet which have very real answers to them.

And then there are the people who are in the refusal group right now who just don't think it's relevant to them. Often young people who just say "No, I'm not interested. If I get COVID, it's not going to be a big deal." Which I think highlights another failure of public health communication in this country, or who think like, "Maybe in a couple of years when I just know more. You can't tell me that we really know enough. I'm not persuadable." So I do think we just have to be cognizant that there are very different reasons why may say not now or not ever.

And then of course there are people who have been themselves or are part of communities that have been mistreated, maltreated by our health care system for generations. So how we address vaccine hesitancy in incarcerated settings has to be different than how we think about that in non-incarcerated settings. How we talk to black Americans, indigenous Americans, Latinos who know that members of their communities have often been mistreated or even manipulated and exploited by our health care system. So, I think we try

at the foundation to really help equip trusted messengers, whether in health care settings or not, we've done work with a number of different religious communities, including some of our Catholic partners to really help ensure that whomever is able to have a conversation really is able to preempt or to answer whatever questions people may have. And even for those who are currently in the refusing group, to message like the vaccines are waiting for you and the procastinators will be too whenever you are comfortable. And, and we are going to keep reaching out to try to help you get comfortable.

So we're just doing everything and anything we can, as I think so many of us are in this moment. And then we're increasingly thinking about how we can engage in this work globally too, because unfortunately vaccine hesitancy and vaccine refusal are not just uniquely American challenges.

And then the last thing I'll say David is just on a personal level. So just need to be clear this is me just speaking as Chelsea and not with the Clinton Foundation or with the Clinton Health Access Initiative is that I personally very strongly believe there has to be more intensive and intentional and coordinated global regulation of the content on social media platforms. We know that the most popular video across all of Latin America for the last few weeks that now has tens of millions of views is just an anti-vaccine anti-science screed that YouTube has just refused to take down.

We know that often anti-vaccine content that is created in the United States, unfortunately flourishes across the world through the pathways of WhatsApp, Facebook, Instagram, and we know that ... because I have tried appealing to the leadership of these companies to do the right thing, has just not worked. And so we need regulation.

David B. Nash, MD:

Well, I'm very glad you brought that up and I hope that with your influence and the influence of the foundation, you'll continue to fight that. And I heard, I think, two key messages from you, which is different messages for different groups, both domestically and internationally. And to think that one message is going to convince everybody obviously, very naïve. And in our great city of Philadelphia, boy, your take homes are still very apt.

Okay. Well watching the time, we have time for one more big important question talking about the future. We'll go in the same order. So here's the question. If we had to build the equitable health care system of the future in our own great country, what do you think the key attributes of that system, if you had the opportunity to participate directly in building this system of the future. So Paul then Walter, and we'll end with Chelsea, what would this equitable system of the future look like, please?

Paul Farmer, MD, PhD:

I wish that you had started with the others, because they're better at the policy questions, but just in terms of fantasizing that it would not be a fee for service system. It would have a safety net that was unstinting and did not leave people out. It would focus on the burden of disease. Where does that burden lie most heavily? Again, there's a Rwandan way of doing that. There certainly can be an American way of doing that. It would look very critically at gaps. After looking at the burden of disease, you would look at gaps, what is not being

addressed? And I think there's some heartening signs from the new US administration that that is fueling some of their thinking as well, the burden of disease and the gaps.

And then just because we're in the middle of a pandemic and I would just point out that even right down to the technical level of how we vaccinate, those are very useful ideas. And to be catholic about it with this lower-case C meaning universal, the same way of thinking safety nets, burden of disease, go where the gaps are and above all, what people are looking for when they're ill is not more disease control, but care, but expert mercy. It has to be the system has to not ignore those who are already critically ill or injured. Because some of the progressive or self-declared progressive groups that are saying we have to focus on the social determinants of disease, yes, of course we do, but we can never leave out the elderly, the frail, the infirm, the injured. And I've seen that happen way too many times in the response to epidemic. It cannot be control over care. We have to be caring, just and universally accessible system.

David B. Nash, MD:

So put the care in health care, that's for sure. Okay. Welter, recognizing the time, the equitable system of the future, what would be your take home message?

Walter Ricciardi, MD:

I fully agree with Paul. Must be a universal coverage system. Either based on a national health service or a social insurance, but certainly not a fee for service. And on a practical point of view, considering this as a public good, we have to convince politicians to invest in health and health care. So not considering health care only as a cost but as an investment. And on a practical point of view, this means investing in prevention, in public health, engaging citizens and making citizens much more responsible about their behavior because only four risk factors are responsible for 80% of the chronic disease and also reorganizing health services. Whenever you have a universal health coverage, of course, your services must be organized on a population health basis. So essentially looking at the needs and demands on the population and meeting these needs and demands rather than offering services that are inappropriate, expensive, and maybe making money for the providers. That sounds utopia. It's not.

David B. Nash, MD:

No, I don't think so.

Walter Ricciardi, MD:

There is a substantial increase in part of the world where this is happening, and I hope that is going to happen everywhere.

David B. Nash, MD:

Great. Okay. Chelsea, you get the last word.

Chelsea Clinton, DPhil, MPH:

I know we have vanishing seconds. I want to emphatically agree with everything Paul and Walter said. I also just think we all need the humility to recognize that there is no equitable health system. There are gross health inequities everywhere. And so, I do think to Paul's good admonition, we need to have enough idiosyncrasy within our systems to really target those inequities, ameliorate them and try to obliterate them for the future. I do think though, so often in the United States, our health care debate is just about coverage understandably, because we don't have universal health care coverage. But I think the equating, excuse me, of universal health care, just the coverage really misses so much of what Walter started his commentary on, that we can't not focus on the health care workforce.

And in this country, we desperately need more well-trained doctors, nurses, community health care workers, trained birth attendants, midwives, health techs. And we desperately need to invest in building the training capacities and the educational institutions for people to be able to be educated and train within their own communities. Be able to not only provide the health care, but to certainly center the care in that work and in that mission. And so, I just ... I think that is hugely an important part that we don't spend enough time talking about.

David B. Nash, MD:

Well, colleagues, I want to say in closing, thanks again for joining us for this fifth meeting. What an incredible group and building the equitable health care system of the future, we all still have an awful lot of work to do. So thanks again and ciao for now. Thank you. And God bless you all.

Paul Farmer, MD, PhD:

Thank you, David.

Chelsea Clinton, DPhil, MPH:

Thank you very much.

Walter Ricciardi, MD:

Thank you very much.