Nate Hagens (00:02):

You are listening to the Great Simplification with Nate Hagens. That's me. On this show we try to explore and simplify what's happening with energy, the economy, the environment, and our society. Together with scientists, experts, and leaders, this show is about understanding the bird's eye view of how everything fits together, where we go from here, and what we can do about it as a society and as individuals.

(00:33):

Today's guest is John Kitzhaber, a former emergency room physician and also the former governor of Oregon. John and I discussed the medical and healthcare system in the United States, which may seem tangential to the Great Simplification, but healthcare is over 20% of the size of our economy, and we get lower health outcomes than many other developed nations. In the future we're obviously in a resource and growth constrained and complexity constrained system. We're going to have to create medical systems that use less energy and money while keeping people healthy. Dr. Kitzhaber has a unique perspective on healthcare policy and its real world applications. He's credited with some of the most outstanding reforms in the nation's healthcare system, including some that are still in effect in Oregon, including the Oregon Health Plan and coordinated care organizations. John is currently active in healthcare reform advocacy, fighting for a system that prioritizes better health outcomes, that meet the triple aim of better health, better quality and lower cost with a focus on community and population health. Please welcome Dr. John Kitzhaber.

(02:05):

Governor, great to see you.

John Kitzhaber (02:07):

Yeah, Nate, thanks for having me.

Nate Hagens (02:10):

You are welcome. You have been a governor of the state of Oregon. You've been an emergency room doc, and now among many of your other pursuits you are working on trying to help the United States have a more sane, sustainable, viable healthcare system. So it's quite the trifecta of experience, and I'm happy to have you here to share your wisdom and insights. Maybe we could just start with an overview of the US healthcare system. So in prior conversations, you and I have talked about this, how

much of us GDP is the healthcare sector and how does this compare to other countries?

John Kitzhaber (02:58):

Yeah, we're close to 19% of the GDP committed to healthcare. It's about twice the average of the rest of the OECD nations, so we're definitely an outlier. We spend about $12,900 per capita per year. I think the second one is Germany at about 7,300. So there's a huge gap there. And the troubling aspect of this is not just the amount of money, but is our health outcomes. We have the highest infant mortality rate among those nations, and we're about three years lower than the average life expectancy for the OECD nation. So we're spending a lot of money, we're not getting the population health outcomes in return.

Nate Hagens (03:44):

Why is that?

John Kitzhaber (03:46):

I think it's due to a number of things. One of them that doesn't get much play is that in a zero sum budget, money that's spent on one set of services is not available to spend on something else. So we spend a huge amount of money on an acute care medical system that essentially fixes broken people. It addresses problems after the fact we spend almost nothing on early childhood, on children, families, and communities on those things that could actually reduce the disease burden in the first place. And the more we spend on medical care, the less we have available to invest on the front end, and it's just this vicious cycle.

Nate Hagens (04:24):

So the USA is approximately 4% of the global population, but I've heard that we write around 50% of the world's medical prescriptions. Is that because we're sicker, we're less tough, or because doctors too easily write scripts or some combination?

John Kitzhaber (04:44):

Well, I do think there's a cultural aspect about America. It's the fast food, quick return, instant gratification. So I think there is a belief or a culture to some extent that says, well, we can just fix it with a pill. At the same time, we've got very limited price

regulations on pharmaceuticals, and we are one of only two nations in the OECD that allowed direct to consumer advertising, fair and low barrier in terms of getting new drugs on the market. And this just incessant advertising. Ask your doctor whether this drug is good for you, and then in the end is this long list of potential complications that they run through so fast that you can't actually understand them.

Nate Hagens (05:29):

Yeah, but they scare the crap out of me when they say that you could result in liver failure, or all this other stuff. How can people actually be marketed after all those warnings at the end? It sounds horrible.

John Kitzhaber (05:42):

Yeah, I'm not an advertiser, but I think the primary message is visual. It's the happy people suddenly recovering from rheumatoid arthritis or some kind of skin disorder, and I don't think they pay much attention to the tagline. And if you've got a problem and it's a real problem to you, and you think that there's a way, some simple way that you can cure that without actually having to make much change in your own lifestyle, you're going to go to your doctor and you're going to ask for that medication.

Nate Hagens (06:13):

So I didn't know this, what you just said earlier. In all the nations in the OECD, we're one of two nations that even allows television marketing for pharmaceuticals. The rest, there's no advertisements?

John Kitzhaber (06:26):

That my understanding. My understanding is that the direct to consumer advertising is allowed in the US and in New Zealand. But I've ventured a guess, and I'd have to check this, that the New Zealand healthcare system has more stringent price regulation. And because the US market is so big, because the direct to consumer advertising is allowed, a lot of these drugs are marketed first here in the US because the profits can be astronomical. If you compare the price of the same drug in Canada and the US, there's just a stunning difference in price.

Nate Hagens (07:01):

And why is that?

John Kitzhaber (07:04):

It's because we don't really regulate drug costs. We allow the direct to consumer advertising, and most other nations restrict the price of medications. They have more stringent controls over the price of medical goods and services.

Nate Hagens (07:23):

So last year we were involved in this survey in the state of Wisconsin where we asked people about their wellbeing and what wellbeing meant to them. And they ranked 10 different things in their life. And a very common response from people was, "I'm afraid to get sick, because if I get sick, I won't have the money to pay for the healthcare costs." And I read somewhere, John, that it's estimated that almost half of cancer patients in the United States will have to file bankruptcy in the process. Is this an extrapolation of what you just said between the US and Canada?

John Kitzhaber (08:05):

It is. I think the actual number of percent that actually go through bankruptcy is much smaller. I think it's 4 or 5%, but over half of them have actually been in collections. And I think the second leading cause of bankruptcy in the US is inability to pay a medical bill right after unemployment, which is to me just unconscionable in a wealthy nation like this. The fact is that the price of medical care is becoming increasingly unaffordable for individuals, for government and for businesses.

Nate Hagens (08:33):

Okay, so you've long been a champion of this issue. In 1994, you got primary legislation implemented in Oregon. That was a different way to provide healthcare called the Oregon Health Plan based on ranking health services by their necessity and their effectiveness. And when the budget wasn't enough to cover all of them, only to cover whatever was the most effective on the list, rather than pushing out coverage for entire people in an effort to increase coverage and accountability. Can you give a breakdown of the thinking behind this plan? Was it politically difficult to implement? What were the major setbacks? How did you get it pushed through? Were there a lot of compromises that had to made? What was the public largely supportive of this or what?

John Kitzhaber (09:18):

Well, it's an interesting story. It actually started earlier than that. It started when I became Senate President in 1986. In those days, the Oregon legislature met every other year. And in between sessions there was this thing called the emergency board, chaired by the Senate President and the speaker of the house that managed the state fiscal affairs. And Oregon, like all states, has to operate on a balanced budget. We can't deficit spend like the US Congress can. And about halfway through the interim, the budget went out of balance and a big chunk of it was in the Medicaid budget. So we gathered together and we took a few votes, we rebalanced the budget, and one of the things we did was drop 4,300 people from coverage. Now to me, it seemed like kind of an sterile accounting exercise. None of us really thought much about it.

(10:03):

I went back home to my town Roseburg and began practicing again in the emergency room. And about six months later, I started seeing some people in the ER who'd lost coverage because of that accounting decision we'd made in Salem. And one of them was a middle-aged man who had suffered a stroke because he could no longer afford his blood pressure medications. And I remember thinking as I walked his wife up to the intensive care unit that I was just as responsible for his stroke as his hypertension because I'd made this decision to drop him from coverage. So what I realized at that point is the way we manage cost, at least at the state level in the healthcare system, when the cost gets too high, we drop people from coverage. In other words, we ration people or we cut what we pay providers, and at some point they stop trying to see people who are on Medicaid in this case, or we increase co payments and deductibles to the point that they're really no longer covered.

(10:57):

So we came back and the next year, Oregon stopped covering Medicaid transplants program, very small part of the budget. It wasn't an intentional decision. It got lost I think in the larger budget for human resources. And six months later, this little boy named Coby Howard showed up who had acute lymphoblastic leukemia, and his doctor wanted him to get a bone marrow transplant. And of course, the state was no longer covering the procedure, so he was eligible for Medicaid, but the program didn't cover that particular service. So they went to private fundraising. This became front page news, not just in Oregon, but around the country and even abroad. And he eventually died tragically. He was not in remission. He hadn't found a match yet. So it's questionable whether the procedure would've saved him, but it was a very

legitimate and moving human tragedy. So in the wake of that, there was an emotion made to refund the transplant program for eight people who had applications pending.

(11:53):

And I opposed the motion. Not because transplants don't have merit, which they do, and not because we couldn't afford it, but at the same time there were 300,000 Oregonians who didn't have any coverage at all. Many of them children, they weren't eligible for transplants, they weren't eligible for immunizations. So it seemed to me that we needed to be more accountable in the way we made these resource allocation decisions. So that led to the Oregon Health Plan, which did a couple of things. It prevented the legislature from rationing people. We put the eligibility in statutes so we couldn't do what we had done on the emergency board of the year before. Secondly, we prioritized health services from the most important to the least important in terms of the health benefit to the entire population being served. And then we estimated the cost of each element on the list with an independent actuary. So we couldn't manipulate payment anymore.

(12:43):

So the legislature just had to make a resource allocation decision and decide how far up or down the list they wanted to fund. Now it's important to note that we didn't prohibit doctors from providing things that were below the line, if you will. It just made it more clear and accountable this connection between the cost of healthcare and the benefit. It was not particularly controversial inside Oregon. It was wildly controversial in Washington DC. We needed a waiver to pass it. Some of the biggest opponents were Senator Al Gore, Henry Waxman, the Children's Defense Fund, who cried rationing, as though the 300 kids who couldn't get access to anything weren't being rationed. And if you looked at the list, services for children and maternity care were very high because they're very effective. In any event, we finally got a waiver. President Clinton gave us a waiver.

(13:36):

We implemented in 1994, we increased payment a bit. So we had a lot of people vying for that population. We've used that list now for 30 years. It's updated every two years. The vote to pass this in in Oregon was 30 to 0 in the Senate and 57 to 3 in the house. So we had broad based support inside the state, and I think it was more of the

sensational nature of an individual and need rather than the needs of the entire population that drove the opposition in the nation's capital.

Nate Hagens (14:06):

So that was quite successful in both keeping people covered and saving money. But as you point out, it would be highly controversial nationally because our culture doesn't like the concept of rationing. Rationing is kind of against the American narrative. Personally, and you and I have worked on some other fiscal cliff and other issues, I think the concept of rationing is unfortunately going to become more necessary in the future. What are your thoughts on this and what sorts of imaginative ways could there be to make rationing of basic needs more fair and effective?

John Kitzhaber (14:46):

Well, a couple of thoughts. First, conservatively 25 cents on every dollar in the healthcare system is wasted in terms of it does not produce a positive health outcome. Overpricing, over utilization, poor care coordination, unnecessary care, etc. So I think there's more than enough money in the US healthcare system to provide everyone in America with all the services they need that could possibly actually help and improve their health. I don't think that's the problem. I think the problem is that we've got an hyperinflationary delivery system that spends almost nothing on prevention, and we need to reform the system and reallocate those resources. The fact is we have always rationed care, usually not intentionally. The man that had the stroke, we rationed care for him. He was never on the front page of the newspaper, so no one really cared. He was invisible. What the legislative bodies do is they focus on the immediate and the visible and the dramatic, and they do it at the expense of needed services that aren't being delivered to many other people. It's just a crazy and unaccountable way to develop public policy.

Nate Hagens (16:03):

Is it possible to host a space where all the interlocking agents and aspects of the healthcare system, payer, provider, laborer, long-term care sectors come together to coordinate and have a real conversation about the whole system and how it works? And this 25% overage that you described, and what would be the first step towards doing that?

John Kitzhaber (16:29):

Well, I've done that twice. I've had two direct experiences. One was with the Oregon Health Plan where we convened after that emergency board debate about the transplant. I gathered together a group, included hospitals, doctors, insurance companies, organized labor and consumer groups. And we developed a set of principles that we all agreed to. They were fairly broad principles. I wrote a couple of them down here for you. All citizens should have universal access to a basic level of care. There needs to be a clear and transparent process to determine what that basic level of care should be. The healthcare delivery system must encourage the use of services and procedures that are effective and appropriate and discouraged over treatment. So we had a set of those that we all agreed on. They're fairly broad, fairly general, hard to disagree with. And then the condition for being at the table is that you couldn't just say no.

(17:21):

If someone proposed a way to reach those principles and you didn't like it, you had to offer a couple of other suggestions that worked for your particular industry that still fit in those principles. And we met twice a month in my office for about a year. And it's very interesting as people began to get to know each other, as trust began to build, things that were hard lines began a little bit softer. And then you could almost feel a point at which people thought, "Wow, we're going to really do something important here, something big here." And at the end of the day, we produced Senate Bill 27, which created the Oregon Health Plan and had that broad bipartisan support. We did the same thing in 2012 when we created what's called coordinated care organizations, which actually did change the delivery model and try to reduce the total cost of care.

Nate Hagens (18:09):

And how effective has that been the coordinated care organization in increasing community health outcomes and reducing long-term medical inflation since that time?

John Kitzhaber (18:23):

It's been quite successful. It came out of the depths of the great recession where if we wanted to maintain coverage for everybody on Medicaid with no new resources, which we didn't have, providers were looking at a cut of around 17, or excuse me, about 37%. So we sat down and figured out how we could look at the delivery model to get more

value for each dollar spent. And the result was these coordinated care organizations, which are community-based organizations with local providers, a local governing board, and their goal is to look beyond the narrow clinical model and focus more broadly on community health. They operate within a global budget of fixed budget that can grow at only 3.4% per member per year. And they have to meet rigorous metrics around quality, outcome and patient satisfaction.

(19:14):

So in the first we operator under waiver, we needed another waiver, which we got under the Obama administration. In the first five year period, all of the coordinated care organizations operated within the 3.4% growth cap. They all met the quality and outcome metrics stipulated by the waiver. We enrolled an additional 380,000 people under the Affordable Care Act, and we saved about $1.1 billion over that five year period. They're still up and running and it's a marvelous change in the delivery model.

Nate Hagens (19:49):

Is this in good part due to your political civic acumen, or is it also related to the fact that Oregon is a relatively low population state? So relative to California or Illinois or New York, there's a lower threshold to get something progressive like this through?

John Kitzhaber (20:10):

I think it's a little bit of both. There's no question that being a medical doctor gives you a certain credibility in the debate. And being a governor also helps you convene the parties. You do need a convener. And Oregon is a small state, you can list on two hands the number of people that have to agree on any given issue to actually get things done. I would argue that it is progressive in the sense that it expands coverage, but it's also conservative in the sense that it manages costs about public sector expenditures. And Medicare Advantage not perfect, but it operates on a, which is in almost every state. It's becoming the majority choice in Medicare. It operates on a very similar matter manner. It has a fixed budget that's determined by counties, and then they're rated, it's called a fire star rating system that measures quality. It's got some real problems. You are able to go in there and game that system through what's called risk adjustment and charge more than you should be getting. And there's been a couple of lawsuits on that.

(21:15):

But if you could fix that part of Medicare Advantage, it's not dissimilar to the coordinated care organizations. So it's not like an unknown entity in red states and blue states. They're all doing it.

Nate Hagens (21:27):

So healthcare is a big drain on our national budget, and we're going into more and more debt. We're over 31 trillion already. But I think healthcare, just like climate change, to address it, we have to deal with the corporate and moneyed interest. I assume there's a lot of lobbyists in the healthcare thing in DC?

John Kitzhaber (21:55):

Yeah, I think of the top six lobbies, four of them are, I think the National Chamber of Commerce is number one, but Pharma, Pharma pharmaceuticals are next. I think the American Hospital Association is in there, Blue Cross Blue Shield, the AMA, yeah, it's a huge lobby organization for sure.

Nate Hagens (22:12):

So technically smart policies such as the ones that you described that reduce the cost spent on medicine or whatever other industry actually decrease the contribution of that industry healthcare to GDP. And so in a culture, in a global culture, but particularly the United States where we measure our success solely through the metric of GDP, these health efficient policies that you're describing actually look like it's making the country worse. So how do healthcare and wellbeing fit into the growth model at the core of the entire system?

John Kitzhaber (22:57):

Well, first, as you know, I disagree with the validity of using the GDP as a sole measure for success and-

Nate Hagens (23:03):

And you went to Bhutan back in the day to look at, and Nepal, to look at alternative metrics?

John Kitzhaber (23:10):

Absolutely. Right, so a couple of comments on that. First of all, the healthcare system has very little to do with health. It, as I mentioned earlier, it's an after the fact acute care system. I prefer, I wrote this down here, the World Health Organization definition of health, which is "a state of complete physical, mental and social wellbeing, not merely the absence of disease and infirmity." So the healthcare system doesn't produce much health on a population basis as we've discussed earlier. It's reflected in our population health outcomes compared to other industrialized nations. A lot of the new technology actually just takes money that's being spent on medical care and takes it as a profit.

(23:51):

A lot of these are publicly traded companies, venture capitalists, private equity funds. So it doesn't really reduce the cost of medical care, it just takes more of the profit out and I would argue drives up the cost of medical care. So the way you deal with the question you're talking about, if we're going to continue to use GDP as a measure of success, is you reduce the spending, the waste and inefficiency in the healthcare system. We need a healthcare system. There are acute problems that need to be addressed. There are chronic conditions that need to be addressed, but you take the difference and you spend it on the front end. You spend it on primary prevention in the very earliest years of life where the seeds, most of the seeds for chronic conditions are planted.

(24:32):

So you are doing two things. You're spending the money, it's running through the GDP, but you're spending it in a different way. It's like comparing the cost of a college education with cleaning up the oil spill in the gulf. They're not the same. And I would argue that spending on primary prevention and health is not the same as spending after the fact on illness. Secondly, if you begin to make those investments in primary prevention, you will reduce the cost of medical care in the long term, and you can use those resources to invest in a transition to a cleaner economy, for example.

Nate Hagens (25:08):

Boy, it's really overwhelming. Yesterday I did a podcast with Dr. Robert Lustig and he said that [93%] of Americans have some sort of metabolical dysfunction in their mitochondria. He blames it on sugar and processed food as the core culprit. But what a mess, because not only is it the monetary drain on economies, but it's the physical

and almost psychic and spiritual drain. If people are sick and not well, we're not as creative or pro future or able to work in our communities. And also, you'll know the answer to this, I heard somewhere that 50% of an individual Americans lifetime healthcare costs are in the last six months of their life. Is something like that true or not?

John Kitzhaber (26:03):

Yeah, obviously we spend a huge amount on end of life care, if you will, on the complications of aging. But the metabolic issue is very interesting. One of my projects right now is looking at primary prevention. We know there's a new field called epigenetics. So it's about a decade old, maybe a little older, that has demonstrated that poor nutrition and toxic stress from housing insecurity, from economic insecurity, from unsafe neighborhoods alters the genetic expression in the unborn child, which dramatically increases their risk of risky behaviors, of addiction, of behavioral problems, mental health disorders, learning disabilities-

Nate Hagens (26:51):

In utero?

John Kitzhaber (26:51):

And that's passed from gener... In utero. And then those problems are either amplified or modified based on the environment of which the child lives. So if you want to really bend down the curve and improve the life expectancy and the full participation of people in our economy, you begin to invest in the first 1000 days of life. You begin to identify the conditions of injustice that exist before conception and during pregnancy, and that's where the resources need to be spent. It's been estimated that 70 to 80% of chronic illness, including addiction and behavioral health problems are planted, are set in place in those very early years.

Nate Hagens (27:35):

But if we were to care about that and if we were to prioritize that, like many other things that you and I have talked about in the past, it would require a longer term horizon. Because any politician that would vote for what you just said, we're not as a nation going to see the benefits of that for 10 or 20 years from now, from the babies are just being born, right?

John Kitzhaber (27:55):

That's absolutely right. And one of the problems with the political system is it does operate on a two year event horizon, and you can't grow a tree or raise a child in two years. So the project I'm working on right now is trying to figure out a delivery mechanism. So it's not just about money. It's taking that money and making sure that it gets to the right children and families at the right time and the right amount for long enough to make a difference. What does that delivery model look like? We're calling it a child success model that we're trying to design and needs to be nested in the community. It needs to be owned by the community, so it can outlive changes in the executive branch or the partisan makeup of the legislature. It's a governance issue as well as a resource allocation issue. But if we can crack that nut, the human potential and the downstream cost savings in social services, in the criminal justice system and healthcare could be staggering.

Nate Hagens (28:48):

Are there other countries that are doing that sort of investing in child and in utero in the first 1000 days?

John Kitzhaber (28:56):

The short answer is I don't know. I know the most other OECD nations do a much better job of spending on the social determinants of health, if you will. If you look at the OECD nations and you look at their total spending on health, which includes medical care and social investments, we're all about the same, roughly. But the US spends vastly more on medical care and far less on social services than these other nations. And I think that is one of the reasons that we see those poor population health statistics that are rather embarrassing.

Nate Hagens (29:30):

So one thing that I learned recently is that processed food with fillers like corn syrup and sugar and things like that, is cheaper. And that real food, which is healthier, that's not processed, if you ate your entire diet with real food, it's like three times more expensive. So there's an income and wealth inequality aspect of food, which leads to the health issues you were just describing, yes?

John Kitzhaber (30:02):

Absolutely. And when you bore down, and we're going to get to this point here in Oregon, if we're able to continue this project, we're going to discover that economic insecurity, poverty, along with racism, is a major driver of this problem. If you don't have enough money, you don't have access to healthy food, affordable housing, childcare, a safe neighborhood, and those are all factors that drive stress and cortisol levels in the pregnant woman. But if we're going to have to step back and if we can get consensus that we need to make those investments, we need to do more of a full cost accounting, look at this problem over a 10 year period. If you made those investments, they're going to pay for themselves six, seven to one in terms of reduced costs in the healthcare system or in the social support system or the criminal justice system. So the solutions there, it's a matter of taking a 10-year view and I think budgeting framework, developing a process to reallocate resources from the back end to the front end and an effective system to actually deliver those resources to get the outcomes that you want.

Nate Hagens (31:11):

So I don't know if you've followed what's happening in the last month or two with advanced artificial intelligence. What about all these new tech venture capital ideas of using tech and AI to squeeze the current inefficiencies out of the healthcare system and in turn boosting their returns? Isn't this an inherent problem that if these companies are successful, they're still taking more money out of the system and not prioritizing the health outcomes?

John Kitzhaber (31:42):

Yeah, I think that's right. And I think if you stop step back and ask yourself what produces population health, only about 10% of your lifetime health status is a result of involvement with the US medical system. The rest of it's your behaviors, it's your environment, physical environment, it's the social determinants of health. And that AI doesn't address any of that. And it doesn't really change the underlying incentives inside the delivery system. In fact, if the US didn't spend so much on healthcare, there wouldn't be so many companies involved in startups that are trying to grab a piece of that pie. I'm not saying that these technologies aren't amazing, but ultimately that don't have much to do with health. They have to do with changing the way we maybe making an inefficient system, making a hyperinflationary system, no less hyperinflationary, but more efficient.

Nate Hagens (32:37):

So you know a bit about my work, because of our interaction in the past, and I'm anticipating this is a little bit of a rabbit hole off of the main thrust of our conversation, I'm anticipating tougher times economically, our energy and material throughput in coming decades will not follow the same trajectory of the prior 50 years. And when I think about doctors and nurses and healthcare, with that alone, irrespective of the things you were just saying, I think we're going to have to get 80% of the medical health benefits with 20% of the resources. I just went in for a little procedure last week and there was disposable plastic and all these fancy machines and just tons of stuff that was single use and gone. And I just wonder, and I'm not talking about a dystopian future, but I wonder if A, can we get a majority of our health benefits with a much smaller input, and B, is the emergency doctor or the medical version of MacGyver going to be a really, really valued social skill in coming decades. Do you have any thoughts about all that?

John Kitzhaber (33:59):

Where we begin. I don't disagree with you, and I don't know the percentages, but let's start with this. I think you can actually do it in healthcare. So let's say 25%, I think it's higher than that, 25% of the healthcare budget you could get rid of and it would not affect the health of the population. Then you go to the fact that 40% of Americans adults have at least one chronic illness, and 60% have one and 40% have two. And chronic illness accounts for about 80% of the healthcare budget. So if you begin to make early investments and reduce the incidence of chronic disease, childhood obesity is a great example. Those kids are going to grow up and have type one diabetes, which has huge comorbidities. Renal problems, circulatory problems, etc. So you take the 25% out, you begin to reduce the chronic care burden, and you can probably get there. But it requires a systemic change.

(34:59):

And I don't want to leave your listeners with the idea that I'm not a big fan of entrepreneurship or private equity or innovation. What if we could say, if you can figure out a way through technology to actually reduce the cost of the healthcare system over time by 6% a year, and you get 1% of the savings, what's 1% of $4 trillion? It's a lot. I just think the investments in R&D in this country are not on prevention, it's

not on delivery system reform. It's on new, fancy medical interventions to deal on the backend.

Nate Hagens (35:44):

So reforming an entire health system is obviously an enormous undertaking. How do we even begin? Is it something that needs to be addressed from the bottom up, top down, or both? And do we first start by thinking about the goals of the healthcare system? What if we publicly stated the goals aren't to generate GDP, but to have an outcome of healthier populations? Is it possible to have this conversation? I remember the vitriol when Obamacare came out in our public conversations, how do we even begin to start this process John?

John Kitzhaber (36:23):

I don't think you can do it in the United States Congress today. I think it has just become too dysfunctional and truly about the next election cycle. So I think the approach needs to be at the state level. What we need from the federal government's flexibility to innovate. And let's say a state like Oregon makes some, let's take coordinated care organizations, for example, if you could seed that to Washington and California and have a regional approach to healthcare, just think about it for a second, you've got three governors, six US senators, 68 members of Congress, and either the third or fourth largest economy in the world. You can reach a tipping point that way. And I think the question we should ask is this one, is the purpose of our healthcare system to finance and deliver medical care, or is it to keep people healthy? They're two completely different things. And most of the things that keep people healthy, most of the things that drive longevity and quality of life are not in the healthcare system. They're established much earlier, and that's the conversation we need to be having.

Nate Hagens (37:32):

The tentacles of the superorganism are just embedded throughout various sectors of our society. I've read that more than a quarter of FDA employees that approve drugs in the past now work or at or consult at pharmaceutical companies. So how big is that conflict of interest within the higher echelons of the healthcare system?

John Kitzhaber (37:57):

It's a big problem. It's not just restricted to healthcare. I think I read an article recently, I think it was two-thirds of the members of Congress who in 2019, the class of 2019, who either were defeated or retired, went to work for some DC based lobby company. So that revolving door I think is a real problem. It's a problem in the financial industry. It's a problem in the healthcare industry. It is a real problem. That's why I think that the reform is going to have to start at a local to regional level. I just don't see how it's going to get through Congress.

Nate Hagens (38:31):

So we started at a local and regional level and come up with pilots of examples of that work, and then other states or other communities say, "Hey, look at what they're doing in Roseburg. Let, let's try that." Because, well, here's another way to frame it. We can either change the healthcare system and then that rolls over into maybe changing GDP or we change GDP as a cultural goal and then fix the healthcare system. Of all the things that we might be able to change, I think healthcare actually might be one because it affects all of us every day. And a lot of people, like you said, 60% have one chronic disease and 40% have two, is that possible?

John Kitzhaber (39:16):

Yeah, I think the healthcare system is the avenue into addressing some of these larger issues. It affects every single person in the country. For the vast majority of people, it's increasingly unaffordable. If you're a small business, it's almost totally unaffordable and in Oregon it's the single largest all funds expenditure in the state budget, and it is the second largest general fund expenditure. It's huge. So I do think that's the place.

(39:42):

And if you look at the healthcare industry, it reflects the corporatocracy that we see across the nation that's causing all sorts of problems. And people want to be healthy. They don't want to be sick. No one wants to stand up in an acute care hospital. So I think it creates a space for a different conversation. Not that it's going to be easy, it is a big industry now, but I do think that it offers a much more personal entree because health is ultimately intensely personal. Sickness or death occurs one person at a time, it occurs to you, which makes it different than almost anything else.

Nate Hagens (40:19):

Well, on that note, take off your policy and politician hat and put on your ER doc hat for a moment. For those listening or watching this podcast, what are three personal recommendations you would give to people who live in this society for their own personal health? I know there's not a one size fits all, but do you have any general advice?

John Kitzhaber (40:43):

Well, I can think of two. And these are from partly experiential. One of them is I think cardiovascular exercise is really important. I run at least three hours a week or inside, outside. I like to run up in the woods. Recently I've been attacked by a Bard owl who thinks I'm-

Nate Hagens (41:01):

Seriously.

John Kitzhaber (41:03):

Oh yeah, yeah. He's actually very cool. I know right where he is. I wear my hat and watch for him, he comes. That's one-

Nate Hagens (41:11):

Wait, do you think he's protecting his family or something? Or he is just playing, or what do you think?

John Kitzhaber (41:14):

After the first time he went over and just brushed my hat with his wing, and then he landed, and I thought he was maybe going after a mouse or something. And then I read this article about this increase in owl attacks in the northwest. Apparently they're very territorial, but he's pretty cool. He's giant. Beautiful bird.

Nate Hagens (41:30):

That's awesome.

John Kitzhaber (41:30):

Anyway, exercise I think is really important. It has lifetime benefits. The other thing, and this may sound a little soft and fluffy, but for the last 35 years, every morning I

find 10 minutes no matter where I am, and I just sit and I try to just be aware of my breath. I try to be aware of my surroundings. I try not to think and just sort of center. And I think that my days are always better when I have that opportunity just to let go of things that I think are really important and just take that time. You can do it anywhere. It doesn't require resources. It just requires a little bit of discipline. And I think it's a marvelous contribution to your longtime health status.

Nate Hagens (42:12):

You're like the 10th or 12th of my guests that have mentioned something about the benefits of slowing down and meditation. Okay. Tougher question, Governor. If you were granted you, you've already said that you think this needs to start at the community level, including some of the initiatives that you're working on. But if you were suddenly Health Czar of the United States, what would be a couple things that you would try and implement right away if there was political support?

John Kitzhaber (42:45):

Yeah, I think the thing that I would do immediately would be to move away from fee for service reimbursement, which is volume-based. The more you do, the more you get spent to what I call value-based capitation. That is a global budget that can grow at a fixed rate that is linked to quality and outcome metrics. That is the future. That is the way we need to go. We need to change the incentive so that you get paid more by keeping people healthy rather than being paid more by doing more. It forces efficiency in your supply chain. It just changes the whole dynamic. That's what we saw with the coordinated care organizations.

Nate Hagens (43:26):

So John, I hope I can ask you a few more personal questions here. Given your lifetime of working with citizens on these issues, do you have any personal advice to listeners? Not necessarily on the medical front, but at this time of global economic inequality, economic environmental problems, what do you recommend to people?

John Kitzhaber (43:54):

I recommend that they don't give up. If we give up, it is an admission that we're powerless and I don't believe that. I've seen over and over again, people coming together in remarkable ways. I saw it, I was governor during 9/11. I've seen it during

mega wildfires and floods. I saw it during the Great Recession. I was in central Oregon where the unemployment rate was 20%, and I saw an extension cord, two extension cords running from one house across to a neighbor's house whose utility had been turned off because they couldn't pay the bill. We have that in us, and I think we just need to tap it now and recognize that these are problems that we created, and these are problems that we can fix. So don't give up. Be hopeful.

Nate Hagens (44:39):

And how would you change that advice for young humans who are teenagers or in their young 20s who are learning about climate change and colonialism and inequality and this healthcare system that they're young people paying into? What recommendations do you have for young humans or young Americans?

John Kitzhaber (45:02):

Well, I guess it's sort of the same thing. I think that if you were, my son's 25 and he looks out at the world that we're living in and he's pretty stunned and not entirely delighted by the prospect, but we deal with the cards we've been dealt. And I think the fact is that we may not be able to see the solution, but that doesn't mean we shouldn't strive towards it. I'm struck by a quote from the Vietnamese monk, Thích Nhất Hạnh, who said something to the effect of, "When I lose my direction, I find the North Star and I go north. It's not that I expect to reach the North Star, but that's the direction I want to go."

(45:42):

And I think we need to have a picture in our minds and in our hearts of what the world should be like. And then our compass during our lifetime is to continue to move towards that vision. And over the generations, we have done amazing things, and we'll get through this. I don't think we know exactly how it's going to require the new thinking, the new tools, the new ingenuity, the new perspective of the next generation. But they need to engage in this fray for sure.

Nate Hagens (46:09):

I like that. John, what do you personally care about most in the world?

John Kitzhaber (46:21):

Well, I guess I want to know in my heart that I have done everything that I could possibly do, no matter how small to leave a healthy planet and a healthy society for my son and his generation.

Nate Hagens (46:42):

Well, you've been working on all these things, ecology, climate, inequality, GDP, healthcare for a long time. So you've certainly been walking the talk as far as that North Star. Now we're stepping outside of just the healthcare system, no longer health czar, but if you could wave a magic wand, there was no personal recourse to your decision, what is one thing you would do to improve human and planetary futures?

John Kitzhaber (47:12):

Well, of course there are always consequences for your decisions. Well, I'll tell you what it is. If I could wave a wand, I would have everyone be able to, for just a moment, move beyond the polarization and the partisanship and all the real and imagined differences we have and the voices on both the left and that are exploiting them. And remember that we have two things in common. The first one is we share a common mortality. We're all going to be born, we're all going to die. That's the reality of our existence. And between those two events, we all walk a path, a very individual path, but it goes to the same destination. And I believe in my heart and from my experience, that all of us in our own way want the same things as we walk that path of life. We want to find meaning and purpose and satisfaction. We want to be valued. We want to add value, and we want to all believe that we have an equal opportunity to succeed, to reach our dreams, no guarantee of equal outcomes, but an equitable opportunity to try.

(48:27):

If we can remember that, if we can remember those common attributes of being a human being, I don't think there's anything we can't do.

Nate Hagens (48:38):

That's well said. Thank you so much for your time today, governor. Is there anything that our listeners could do in their own lives, in their political decisions, in their communities to help the efforts that you were talking about, your community models,

or how can they learn more about it or get engaged or what can people do listening to this that would like to contribute to changing the healthcare system?

John Kitzhaber (49:07):

Well, I don't have an organization. I've got a blog that I could send you the link to where I post on periodically. But I just think we're much more empowered than we think, but we do have to get to root causes. And we've tossed to some of them about some of them, about of them today. And I think it's an exciting time to be alive. And someone said once that there's no survival value in pessimism. And I believe that.

Nate Hagens (49:34):

Yeah, I feel the same way. This podcast and talking to thinkers like yourself and all the projects that you're working on is exciting. It's daunting, but it's provides meaning and direction. Thank you so much, and good luck with your projects in Oregon, and we'll definitely continue the conversation.

John Kitzhaber (49:55):

Great. Thanks very much for having me, Nate. I appreciate it.

Nate Hagens (49:59):

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