Framing Health's Future

Preparing for the next crisis

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Sophie

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It's hard to overstate the devastating impact of COVID 19. We lost more than a million American lives, there were 33 million hospitalizations, the mental health consequences continue to exact their toll, and countless individuals continue to suffer the physical effects of long COVID. Every American was touched by the pandemic, but some populations were disproportionately impacted, either due to pre existing conditions, unique vulnerabilities or social inequities.

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According to many thinkers, the next crisis will hit before we've had a chance to fully recover. As we continue our exploration of preparing for the next crisis, today we will discuss the cost of inaction. What is the scale of harm? Who will pay the price? And what should the government be doing now to support those most at risk?

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I'm Sophie Stern, host of Framing Health's Future, an initiative from the federal health leaders at KPMG, and I'm delighted to have with me today. Dr. Georges Benjamin, Executive Director of the American Public Health Association and former Secretary of the Maryland Department of Health and Mental Hygiene and Deputy Secretary of the of Public Health Services.

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Larry Levitt, Executive Vice President for Health Policy at KFF and former Senior Policy Advisor to the White House and the Department of Health and Human Services during the Clinton Administration. And Estelle Willey, the Director of Health Policy and Communication at the Rockefeller Foundation. She is a leading media and global health strategist and an expert at knowledge translation, coalition building, and information ecosystems.

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I'm very much looking forward to a dynamic and productive and most importantly, actionable conversation today. Let's get started.

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Welcome everyone. I am so excited for today's conversation, which is preparing for the next health crisis, uh, specifically the cost of inaction. So Larry, let's, Let's start with you. Um, when we're looking at the cost of COVID 19 pandemic and the multiple facets, I'm just curious, you know, we immediately think of the visible indicators, so the massive loss of life, the number of days spent suffering with illness, often serious, the life milestones people missed, but what are the less visible consequences of the pandemic from your perspective?

Larry

[00:02:20]
Well, I would start with, uh, the loss of faith in expertise and science. Um, I mean, that has allowed misinformation, uh, to spread. Uh, you know, certainly starting with, uh, COVID vaccines and COVID treatments, but spreading well beyond that. Uh, and it's, you know, it is a byproduct of COVID and the response to COVID and the political divisions.

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surrounding that. Um, you know, so we now have a loss of faith in vaccines among among many people that go beyond COVID vaccines. Um, and, and that's going to make it, it's making it harder to address public health and healthcare issues generally right now, uh, with the rampant spread of misinformation, but it is certainly going to make it harder to respond to a, to a future health crisis.

Sophie

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Absolutely. And I think, you know, Estelle will ask you to touch on this a little bit later, because in your role, I know you were up against some of that loss of faith immediately in, in the height of the pandemic, um, and are also focusing on kind of how to, um, reconcile with this, this new reality, um, coming out in preparation for the next health crisis.

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But I think that that, um, definitely resonates, Larry. And I guess, you know, Dr. Benjamin, if you agree, if that it is the most underappreciated, um, kind of impact of COVID 19, but then beyond that, if we were thinking about the populations that were impacted by COVID 19, if you could give our listeners just a sense of, you know, who those populations are and, and what was the true impact?

Dr. Benjamin

[00:04:00]
No, I think Larry's absolutely right. I think the undermining of our. baseline for authority. Our respect for getting expert advice was severely undermined. Um, and it had very corrosive effects as this went on. Um, and we saw that in many ways. I like to think of three populations of folks that were impacted by covert early on.

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It was people who were more likely to be exposed to the disease. These are people who had to go to work. They had the bus drivers, the service industry early on, healthcare workers, for sure. Those people were much more likely to get infected because they were being exposed to the disease, where many of the rest of us could go home and, you know, work from home.

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And we weren't out and about. The second thing was people were much more susceptible that if they got infected because of underlying chronic diseases, heart disease, lung disease, kidney disease, those people were much more likely to get if they got infected, get really sick. And disproportionately, those were people who had disparities begin with.

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Particularly communities of color, lower income individuals who didn't have healthcare access. And then the third group, which feeds into Larry's point is those people that were susceptible because of the political environment they were in, where they got a lot of misinformation and then, in some cases, purposeful disinformation.

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So they didn't mass. They didn't social distance. They did not take the vaccine when it became available. Those people were at higher risk as well. So, you know, and if you think about it, all three of those, um, are structural things in our society that we, um, um, needed to fix as the pandemic went on, and in many ways we haven't, we haven't really fixed it yet.

Sophie

[00:05:51]
You know, and I, I like how you've kind of broken out the, the different populations that, that were impacted, and I think something that is still very much a part of the conversation and needs to be is how the people supporting the healthcare system fared. And the impact of their experience on the future of our healthcare system, just from a burnout and mental health perspective, but I would, I guess my follow up to that, Dr.

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Benjamin or Larry Estelle is, if you think about the workers, you think about, um, the populations that were maybe inequitably affected, and then you think about, you know, the people who were impacted because of the misinformation, You know, how are those populations faring today?

Dr. Benjamin

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Well, I think we put in place a lot of things that actually did good work. So we addressed misinformation, um, in populations that were quite skeptical. And we actually saw a narrowing of those disparities initially. Um, of course, we went back to the old system. And those disparities in vaccine coverage, for example, are beginning to recur.

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We put in place ways to get people health care, um, to their pharmacists. We range, we expanded the number of people that give shots to be able to get medications. And then we went from what was in essence, a all payer, single payer healthcare system for COVID. And then we went back to our usual patchwork system.

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And then all the flaws in our usual patchwork system, of course, are now reemerging.

Larry

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Yeah, I would I would agree with that. I mean, early on, when when vaccines first became available, the disparities across racial and ethnic groups were enormous. And as Dr Benjamin said, we closed those over time. Um, you know, for example, learned that community health centers were key to reaching, uh, low income communities and communities of color and directed funding streams to them.

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A lot of those funding streams have now ended, uh, leaving us now unprepared once again. Um, and, and when you think about sort of the early roll rollout of testing of vaccines, you know, as Georgia said, it was Medicare for all for COVID. Um, there were no networks. You could go to any pharmacy, go anywhere.

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to get a vaccine, uh, to get a test. No out of pocket costs. You know, once that ended, once the public health emergency, uh, ended, you know, it's now back to provider networks. You don't know which pharmacy you can go to. Um, and you know, we're seeing those, those access barriers returning.

Sophie

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So, you know, when you're thinking about kind of the, um, the access barriers that were removed during this period.

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Was incredible kind of what we saw manifest because of it. And to your point, some of those benefits are now being rolled back. You know, there's, I think some would say very good reason for that, largely driven by, you know, economics. Um, but do you, Speak a little bit to kind of what is that right balance of, you know, it went in when you're in a crisis, there's a certain response when you're coming out of a crisis, there's a certain response.

Estelle:

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And then ideally you would reach a steadier state at some point, understanding that you still then need to prepare for the next crisis. We can't forget. But like, what is it, what is that balance?

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We have to think about public health in a steady state. Um, we can't just keep. Doing this like panic and neglect cycle where we ramp up, ramp up, ramp up in the middle of a crisis.

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And then after the crisis, we slow it down and expose everyone to like the patchwork system that Larry and Benjamin were talking about earlier. I mean, I think for me, the biggest issue that surfaced with the COVID 19 pandemic was actually the disintegration of trust trust. Within American people and the unraveling of the social fabric that is America.

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And that's way beyond public health and is way behind one, what one public health worker can solve for in the middle of a crisis. But let me tell you in this patchwork system that we have, which is very much based on local jurisdiction, state, um, State programming and you know, it's, it goes back to the founding of our country of really like state rights versus the federal government.

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Um, we live in an environment where progress only happens at the speed of trust. And how does that happen? It happens through decades and decades of work of support systems that really value the end user, not top down approaches.

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And, you know, you see it in Navajo Nation, who was able to vaccinate 90 percent of their population very quickly. You see it in New Mexico where the public health infrastructure was so clearly set up for success. And I think that is where COVID 19 and The opportunity lies within our response, um, because we were able to move quickly and really show how if we did things differently, it can be effective.

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But now we're facing this big question of, is there a true commitment right now to actually sustaining and expanding evidence based initiatives that improve health equity and save lives?

Sophie

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That is the question, um, and, and before we go there, because that is a very important question. I just want to kind of dig into this, where you're going in terms of, you know, the real time adjustments that were able to be made.

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So, you know, I think one of the greatest challenges in the COVID 19 pandemic was just how unprepared we were, you know, particularly when it comes to vulnerable populations. And yet we were able to undertake, I think to your point and Dr. Benjamin point, Dr. Benjamin's point, some real time initiatives to improve health outcomes.

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Um, so. Estelle, can you talk a little bit more about, you know, maybe one or two of the programs you and the Rockefeller Foundation were able to initiate and, and perhaps any aha moments that can be applied to the next health crisis, you know, things that we might need to make that commitment to, to invest in, um, you know, starting today and, and into the future.

Estelle:

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Yeah, sure. So try to be quick because we, We worked on a lot of different things, but I think like two big examples. One is working with school communities, um, before vaccines were available. Um, one of the biggest issues was about reopening schools and reopening them safely. And how do we do that with Young kids, teachers, and really making sure that teachers are comfortable.

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School administrators are comfortable. Parents are comfortable and kids feel comfortable. And that's like a, that was really, really tough. But I think the thing with philanthropy that makes us really useful in these times of crises is that we can really pilot and test. Something out a hypothesis and rapidly, um, get the evidence of the impact of the effectiveness, efficiency and whatnot to see if that type of program can be scaled through the federal government.

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Um, so we've actually worked with the Trump administration and the Biden administration on this K through 12 testing program, which, um, you know, we implemented routine testing program where we, you know, tested students and teachers twice a week and wanted to see if that would actually make a difference.

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And I think the biggest aha moment for us was. The role of community, um, in this, the role of the parent, the role of the teacher in actually making sure that a testing program, a child felt comfortable with a testing program, a parent felt comfortable bringing their kid to school. But I mean, a mom who has like 5 million things going on, Putting this on her and burdening her with another thing to be responsible for is a lot to ask.

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Same with teachers, um, same school administrators. And it was a huge moment where it's like, let's just take a step back and think about user experience and like, think about it from like a marketer's perspective. And all of this stuff just seems like. a no brainer, but it was just like these types of things in the middle of crisis that you might not think about when you're like, everyone needs to do this.

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It's going to save your life. And like, please just listen to us. Like, you just can't do that. So that was one aha moment. And when the vaccinations became available, it was really how, how do you make this seem like not a burden for them? Uh, right. But it really is the local food pantry manager. Who's giving.

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you know, food to a family who's really suffering during the pandemic that could just say, Hey, do you know if you just go to next door, you can get vaccinated really quickly. And that could really help you get your next employment opportunity. Cause they're going to mandate vaccines. It's going to, it's going to help say like help you with your medical bill.

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Like, you know, all of that type of conversation that could happen person to person. That's not going to come from a public health commissioner sitting in the state capitol.

Sophie

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And what I'm hearing, Estelle, is, you know, one, it's the aha moment is in the role of the community. But people that you're relying on in that community are not necessarily a part of the public health system.

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Exactly. And in order to call those people to action, They need to trust you, and if that trust has been eroded, it makes that job that much harder, but it also emphasizes how much more important it is to establish those trusted relationships and maintain those relationships in advance of any next health crisis.

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And so I think that's just something that we just have to hold and focus on and continue to focus on. Continuously as a public health community, but just honestly as a community.

[00:16:49] Estelle:
And I also think we need to think about information as another social determinant of health and how we access information, assess that information and act on it is just really.

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important, um, because at the end of the day, public health guidance is all about making people do something that they don't really want to do. Um, it's inconvenient or it hurts or it's just weird. Like, well, how does this affect me? And I think, um, That trust is what really helps with making people take that action.

Sophie

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I actually, I really, really like that and I'm going to ask Dr. Benjamin and Larry to opine on making that a social determinant of health in a few moments here. But before I do, I want to kind of pivot to the early warning signs during COVID 19 because with any public health emergency or any health crisis, there are always early warning signs.

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And so, Dr. Benjamin, you've talked about how. From a structural perspective, every emergency is like a new emergency, and this stands in strong contrast with our response to natural disasters where we've established institutions and processes are our defense and intelligence community. Can you share your ideas for the federal government when it comes to incident command structure in the in a public health crisis?

Dr. Benjamin

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Yeah, yeah, it's pretty clear that we understand if, um, um, we have something we see coming like a hurricane or. Um, because it's hurricane season, um, or we have an acute emergency where there's a volcano eruption or a earthquake, something that we weren't anticipating that happens acutely. The emergency response system in this country knows how to respond.

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They, the person is in charge is clearly identified early on. Uh, all the agencies understand their roles, uh, and they respond in that manner. Um, it's a very organized. system with the goal of going from chaos to control disorder as quickly as they possibly can. With health emergencies, um, we, they tend to kind of creep up on us.

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And for that reason, we often don't have, um, an identified command structure. on how to respond to them. So we always seem to be late getting a all of government, um, response, um, and all of emergency response to these things. You know, we're always in many ways chasing their response. Uh, which is a problem, and I think one of the things we have to do is, first of all, be real clear about how we want to handle health emergencies, not just infectious diseases, because COVID's been a problem, um, but we've been, we, we chased the opioid epidemic in the same dysfunctional way, chased the obesity epidemic in the same dysfunctional way, and quite frankly, even some of the chronic diseases, we could do a lot more effective, um, response if we really responded.

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earlier by kind of activating things. You know, we always seem to be afraid to bring people into a command center and have a much more organized response because we're afraid we will scare the public. We will raise people's concerns, um, disproportionately to the response. And, you know, as an ER doc, um, I learned early on that throwing everything you can at something earlier, but at the appropriate time, uh, is a much better way to do things.

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And what we think about that is trying to keep all these systems warm in a way so that you can scale them up quickly. Uh, and that includes engaging the community. I mean, Stell talked about getting the community engagement. That's We brought communities very actively involved in COVID. Uh, and then we just kind of threw them away.

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And that, that turns out that doesn't work real well when you want to maintain community trust and engage them in an effective way. So having an incident command structure, um, where we know who's in charge, how they're going to operate, and activating them early, I think is the way that we need to have a new operating environment for health emergencies.

Sophie

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Larry, is there anything you would add to that?

Larry

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I certainly agree with that. And I would broaden the discussion. And, you know, particularly COVID, but not just COVID, it certainly applies to opioids as well. You know, there's an economic crisis that often comes along with a health crisis. And we found ourselves scrambling to deal with both at the same time.

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And it ran the gamut. I mean, it was, Um, how to provide relief to states, you know, who saw their revenues plummet and at the same time needed money to respond to the public health crisis, uh, health care providers, you know, which saw their revenues, you know, fall through the floor as people were not getting health care for anything other than COVID, uh, and had all these other needs for, PPE and, uh, and equipment.

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Um, So how do you get money to the providers and to the right providers, uh, quickly? And we did that very poorly early on. Maybe we can talk about that a little bit. And then Estelle talked about, you know, the data reporting, uh, you know, that, that, uh, that that was horrible. I mean, we, we, uh, you know, You know, we suspected there were these racial inequities, for example, uh, but didn't have the data to, uh, to document, document them.

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And that took time, uh, to, to create. And now I feel we've lost some of that, that capacity, um, to, to respond to a, to a new crisis. Um, so it's, it's that idea of having, having things in place and ready to go. Quickly, um, including personnel, community health workers, uh, and being able to call on that. And we, we are not good at that.

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I mean, it's, it's just too easy to say, Oh, you know, we don't, we don't need that funding anymore because there's no longer a crisis. So we're going to redline it. And then you've lost it.

Sophie

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And that's what we're seeing today, quite frankly. And I, I guess one question, I have this question for all of you, and this applies to COVID 19, but Larry, I appreciate you broadening the conversation because this is, It's meant to be not just about COVID 19, but what we do next is how do you get people to take action or take something seriously when they can't see it, when they can't do it?

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feel it or don't trust the information.

Larry

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Well, I, I, I would make a couple of points. And one George's made made that, that you, you need to be transparent with people. You know, there is a sense that if we are mobilizing to respond to a crisis that we're going to scare people. Um, and the result is you end up giving people mixed messages.

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and lose trust. Um, so, you know, being transparent, I think, is really important. Um, and thinking really carefully about who trusted messengers are, you know, whether it's the food pantry worker, uh, like, like Estelle said, but others as well. So, for example, our survey work has found that local news is a very trusted source of information for people.

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Um, it's not always the most sophisticated coverage, uh, but maybe we can build some capacity to make it more sophisticated, to provide expertise that local news stations can rely on. But it's that local news channel more so than CNN, Fox, you know, MSNBC, that, that people find trustworthy, uh, in, in a crisis like this.

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I think for, For me, there have been many initiatives that occurred throughout the COVID 19 pandemic in pilot phases that really helped build trust, actually rather quickly. You know, there was a program in Maryland, um, where they trained barbers and beauticians on talking about COVID with people that they were doing their hair with.

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But, as Larry was saying, Funding has been cut for these types of programs. So, I mean, a philanthropy like Rockefeller, we can put the pilot money in. We can test these out. We can provide all of the insights, but at the end of the day, a government main purpose is to protect their people, their citizens. And we need to see some domestic, um, Spending on this and domestic privatization on it, and it's just not there because it's become this politicized animal, if you want to say, and I think the way forward and how we move beyond this is, um, it's going to sound a little controversial, but we need to start thinking about the actual incentives that increase budget.

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Increased budgets for this type of thing. Public health has been, is very objective. It's scientific. It's based on numbers. It's black and white. We, you know, we evaluate something. We take it very seriously, rigorous evaluations. We publish it in peer reviewed journals. At the end of the day, someone just needs to understand that what we're trying to say and our, our, our recommendations are.

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science based, but they have to be user friendly. And I want to give an example that's not COVID 19 related, but it's actually around HIV. The early 2000s new data came about saying that if you take, if you have HIV and you take your treatment regularly, you will not transmit your HIV. virus to your sex partner.

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Early 2000. This research though, it didn't say you had a 0 percent chance. It said you had a 0. 00000000001

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percent chance. And that made the scientific community like contort themselves into a pretzel because advocates were saying, can you just say you don't have any risk? What's the risk here? Is it, will you transmit, will you not transmit, because there was other data showing that if you didn't know your status, it was a 9 out of 10.

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Transmissions were coming from people who had HIV, weren't taking their treatment, and didn't know their status. So what do you do here? And I, I saw it firsthand. You were seeing these IPEX trials about pre exposure prophylaxis, which is a medication that could like reduce your risk. There was this other conversation about, should you be taking your treatment?

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And should we be saying no risk? And it was this whole shift in, in how we were talking from, you have to wear a condom every single day. So that you don't transmit HIV to you take your treatment, you won't be transmitting and it took 16 years for the public health community to start talking in messaging that the community understood and this is our problem.

Sophie

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And that's really interesting. It's still because I, you know, my takeaway from that, and I've actually lived this experience working in different organizations, trying to get messages out to the public, particularly around enrollment into health insurance coverage. But as the power of. multidisciplinary teams.

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So you need people that think differently to solve a problem. So like, if you take a public health scientist and you pair them with, you know, a communications person, they're going to think very differently and probably have some arguments in terms of how that message should ultimately go out, but we're going to be better because of it.

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Um, so no, thank you. Thank you for, for sharing that. And, you know, as I, as I'm listening, it's like, we, we know what works. We've been doing it for decades in the public health community. We know the importance of a trusted messenger. We know the power of community. We know the power of information. But what I'm sensing into is it always comes back to the money.

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I think Dr. Benjamin, a year ago when we were talking, you used this phrase of no money, no mission. Organizations need money in order or financing in order to act on the things that we know that work. So, So Larry, I'll turn to you to say, you know, our public health response to COVID 19 required so many institutions, including states, health systems, community health centers, all of which needed financial support and continue to need financial support to prepare for effective response, to prepare for and respond to the aftermath and to continue to prepare for what we know will inevitably be a future health crisis.

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Can you talk a little bit about how the government distributed the dollars and what can we learn from that experience?

Larry

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Yeah, and there there were different streams of money, right? There was the, uh, provider relief funds. Um, and that money got out there fast because we use Medicare is the mechanism, but that had some challenges.

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So, for example, uh, pediatricians don't participate in Medicare. You need some way to get money to pediatric practices. Uh, the money was not correct. It was distributed scattershot. It was not, um, targeted towards those providers that, that truly needed it, uh, because they had low margins, uh, little cash on hand, uh, or were safety net institutions, uh, that were serving the communities like Georgia started with.

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I mean, the folks who still had to go into work were, uh, were at greater risk of being exposed to, to illness. Uh, the money was not, uh, targeted at the providers and institutions that were serving those, those communities. So, you know, we, we didn't, the money got out there fast. It did not necessarily get out there in, in the best way.

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Uh, states needed money, uh, and we had the ready mechanism of Medicaid to get money to them. It's very easy to just add, add some to the checks that go regularly to states to, uh, match, match Medicaid, uh, dollars. Interestingly, that came along with a requirement that people keep, that states keep people enrolled in Medicaid, not, not kick anyone off Medicaid, uh, during the, the public health emergency.

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Now, I don't think anyone expected that to last years. Uh, and, uh, I think we would think about that somewhat differently. differently if we were going to do it again, if we knew we had a crisis that was going to last years. But you know, interesting, if you look at these funding mechanisms, Medicare, Medicaid, those are all entitlement programs, right?

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And that is how we fund our healthcare system, is through entitlements. Um, you know, there's no annual budget appropriation required for that money. The money just flows. to the healthcare system. Our public health system doesn't work that way, right? Our public health system is not an entitlement. It's, uh, an annual appropriation, much, much easier to cut, uh, than, than these entitlements.

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And I think that's why you see this tremendous funding disparity, uh, between healthcare and public health. That's

Sophie

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An excellent point. And I think, you know, something that often gets lost is, you know, how things are paid for, um, fundamentally impacts the way that people ultimately can access. Certain benefits.

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So in terms of measuring the cost of an action, right? So I think it's, we, we know what works, maybe we didn't do it as well as we should have, um, in response to COVID 19, we know that, you know, financing and funding pilots is absolutely critical. We know that financing is incredibly important, um, to states and local communities.

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But Larry, can you talk a little bit about what the macroeconomic and social impacts of a public health crisis are that lead government leaders should consider what should government leaders be thinking about today?

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Larry: Yeah. And I think I, you know, I, I go and this, this isn't and shouldn't just be about COVID, but I, I take myself back to the, to the early weeks, um, uh, of the realization that there was a pandemic and the, the economic dislocation was just so enormous, you know, millions of people were getting laid off from, from their jobs.

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And I, I remember looking at the numbers and thinking, my God, we, we could have. Tens of millions of more people uninsured, um, as a result of this economic dislocation. The numbers were just eye popping. Now, fortunately, that didn't happen. It didn't happen for a few reasons. One is, uh, the massive economic dislocation was in many ways temporary.

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People were furloughed from their jobs and were ultimately brought back. Still took us a long time to get back to that pre pandemic economy, and we're still dealing with higher prices, but it also happened because of policies. So, for example, I mentioned that states got relief in return for Uh, a prohibition on kicking people off Medicaid.

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The result was that, you know, over 20 million more people were covered in Medicaid, uh, at the height of the public health emergency than were covered before, uh, the, the pandemic. And this was kind of, you know, in some ways correcting a problem we've always had that people when they change circumstances fall through the cracks, you know, they, they get a job with higher income.

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Um, they're no longer eligible for Medicaid. But they don't make it to any other part of the system. They don't make it to the Affordable Care Act marketplace where they can't afford their employer coverage. Um, so we, we had the system that kind of filled in those cracks for a period because people couldn't get kicked off, uh, their, their health insurance.

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I would hope that there are some lessons in that, that we've learned that can Take us into the future. Um, so for example, states have improved their renewal systems, uh, for Medicaid using databases that contain people's income. So you can automatically renew someone in coverage. Uh, hopefully that will lead to fewer people falling through the, the cracks, uh, in, in the future.

Sophie

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Sophie: And, you know, we've talked about the role of the federal government, um, you know, the importance of states and local communities. And Estelle, you've, you've touched on. This but the found the role of the foundation and the philanthropic community. I guess I would be interested in your perspective in terms of when you're thinking about, you know, funding, financing, getting money into the hands of the people who need it to affect change.

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What is the role of philanthropy versus the role of the federal government or even, um, you know, private We'll Organizations and private business. What have you learned? And I guess, what would you hope that people kind of would take away from this conversation and from, from that context?

Estelle:

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Estelle: The federal government has to be thinking of things in terms of reaching billions of people.

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I think philanthropy. can look at reaching millions or thousands or, you know, a much smaller group of people. And I think when you think about in that context, we have a lot more options to be riskier, to take those risks and to, you know, test out hypothesis that the federal government might not necessarily do because it's just not, you know, The data isn't there.

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And if they fail, they feel a big way. You don't want the federal government failing like that. Um, and I think so. That's the philanthropic point of view. And then I also think the private sector brings a lot more than just money. Um, they bring the technical expertise and the capacity building, but it only works when something becomes considered a material risk for their actual business.

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And once you identify something like that. And pair it with government priorities and strategies. It really can be a win win, but you have to, both sectors are talking in different language. So really bringing them together is like, is an art, um, and a science. So I think that those are two things. And I, and I mean, during the COVID pandemic, we actually, um, we actually did something that helped with the financing for states.

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It was called the state and territory Alliance on testing and the Rockefeller foundation actually served as the guarantor for states to use state budgets to purchase tests. And in a much. more convenient and streamlined process that, uh, wasn't going to happen if states had to do it on their own. And because we were the guarantor, we were able to remove the risk for them to make these purchases.

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And, um, we were, we able to bring Amazon on board. I health, which was a testing manufacturer and care evolution to create the website, fancy, fancy website. Um, but really it was just put your zip code in and you get tests, but it really helped. Streamline a process that for state government could be really, really onerous and it could have taken up to a year to create, um, with all of the processes in place.

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So, you know, um, we all know the testing program that ended up happening from a federal government where you put your zip code in and you would get free tests, but that actually started as a pilot program in five states, um, where we were the guarantor and states could use their money to purchase tests.

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They decided which zip code, um, would be eligible for the test for Kansas. For example, anyone in Kansas could get it in, um, other States. They focused in on different vulnerabilities. Put in your zip code. I health would work with Amazon and Amazon would bring the test. They would put it in their warehouses and then they would.

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Allocate them accordingly, just based on a normal Amazon driver's route. And that was fantastic. And it really helped move the needle and show the impact of like a streamlined service that then got taken up by the federal government. But I think the key lesson here more than just the delivery, um, and the development of this private public partnership was actually, it brought together all of the states.

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Uh, this the focal points from states in every single state that was working on this together, and they started meeting once a week, learning from each other about all sorts of things. And then more and more states who are not even part of this and you know, the advanced market commitment process for testing started learning about it.

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And now there are over 2, 900 state and local leaders. In this program called stat, which needs to be renamed because it's not just about testing and they are learning from each other, from all sorts of stuff, not just COVID 19, obviously, but for early warning systems for H5N1, um, you know, like hurricane season is coming.

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What are you doing in your state? What are you doing in your state? And it, it's to the point where, you know, 85 percent of those 2, 900 people are from state, from states. working in state governments and local jurisdictions. And then 40 percent have said that they have implemented something that they learned from a stat call in their own work.

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So like during COVID, we had Texas reps come in and talk about CLIA waivers. Like how did you get a blanket CLIA waiver so that anyone could implement a testing program? And a lot of States then were like, All right, I'm taking notes and we're going to do the same thing. And then they were able to get a blank.

Sophie

[00:41:30] Sophie:
That's fantastic. I mean, it actually reminds me a little bit of the echo model, which, you know, is more in a medical setting, but it's just the power of, of networks and collaboration is really, really incredible

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when you think about the people that are most impacted public health professionals were really impacted with their mental health and what they were doing.

Estelle:

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And I think this, this kind of commodity, like you're in it together. We're going to learn from each other. And we're going to really, you know, we're here for each other as peers. I think that was such a fantastic story that hasn't really been told, but, um, just know that it is continuing. Um, and you know, the CDC has endorsed it, but it is a, And when you're going back to your question about the role of philanthropy, this is also something that the role of philanthropy can do because we're objective.

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We're not seen as, you know, a political party and we can support efforts like this that might not necessarily, we'll be able to like measure the impact of it, um, through election cycles, you know, but it's something that's really important and can serve as, um, you know, like a catalyst for that change that's needed.

Sophie

[00:42:41]
I mean, arguably, the federal government should be able to, you know, do similar types of activities and there are incredible pockets of innovation within the government. And I guess my follow on question to that would be in terms of the collaboration, I would assume that you're sharing lessons learned with the government and back to kind of magnify and scale.

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Is that a correct assumption?

Estelle:

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Yeah, absolutely. But you have to remember that public health is on a state by state basis. Absolutely. Some of the biggest questions right now are on data collection and standardization. Like, how do you make that easier between states? Like that type of conversation is what is like the feedback loop and you know, federal government, there's people from, that's why it's only 83 percent not a hundred percent of states participation.

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Like some of it's federal, some of it's nonprofit, some of it's, you know, the Rockefellers in the world, but, um, it's, it's truly a very cool network. Yeah. Yeah.

Sophie

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And I mean, I think that that is one of my takeaways is, you know, it's a patchwork of different organizations and leaders at different levels that is going to require a commitment moving forward.

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It can't all fall on, you know, one entity to drive us forward because that just wouldn't be sustainable or feasible or possible. I think, you know, one question for for all of you really is as we're thinking or coming to a close and we're thinking about. Kind of the future, you know, ultimately, what is the cost of inaction on vulnerable populations or populations, you know, more broadly.

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And I guess in other words, if we don't take steps now to embed what I like to call a preparedness mindset at the federal level, or really any level, you know, who, who is going to suffer the most?

Dr. Benjamin

[00:44:32]
Well, you know, it's, it's clearly money, lives, optimal health. Um, I think the first thing we need to do is we need to start counting differently.

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Okay. Um, our challenge, I think, is that we only count the amount of money we put out for response. We don't care for the opportunity costs. That doesn't get captured. We don't bill the standby costs, um, so when something happens, it always costs us more to respond than it ought to, um, if we had kept our systems warmed and ready.

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Um, and then we see that. In the lives loss. You know, we tragically counted all the people that tragically died from Covid. We're still counting and we will continue to count for years to come. The long covid cases, um, and those, those costs, uh, and quite frankly, we're not capturing those costs real well.

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We're looking at. their health care costs, but we're not looking at their costs of inability to go to work. The lost futures, all those things are not not captured. When you put all that together, it probably is much cheaper for us to have a system with everyone in and nobody out and and build a preparedness system that can respond to emergencies a lot more effectively.

Larry

[00:45:47]
And I think if you think of The cost of inaction more broadly, uh, you know, not simply people's health and lives as important as that is, uh, it's the economic cost as well. And we saw that so clearly, uh, with COVID, the potential for a public health crisis, uh, that is not managed quickly and well, uh, can spread.

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Can become an economic crisis. Uh, and that can also take years, uh, to to recover from. So the the opportunity cost of of not responding, uh, is is not just in health. It's it's in in our economy as well.

Estelle:

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Absolutely. Let me add one last thing. So it's lives lost. It's like the economic cost, but it's also can make or break elections.

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It could make or break national security, and it can make or break your fiscal space for your budgets. So, I guess that goes back to economic return on investment. But just to add a few more things, I mean, I think we saw COVID 19 really put pressure on elected officials. whether or not they knew anything about public health, whether they were there to, they were there for a long time to help increase infrastructure, or they were just elected into this mess.

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They were very much active and engaged because their constituents cared. And I think if more and more of these types of things happen, They're going to be in the hot seat and I think that's another thing that the public health community hasn't really been thinking about is how do you, how do you make this something that is an election issue, right?

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Something that politicians care about.

Sophie

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So, you know, if what I'm, what I'm hearing and I, I very much agree with is that our country can't afford the cost of inaction. And it is not just on the public health community to figure this out. This is a broader, um, issue given the kind of tentacles of a crisis and where it leads to, um, beyond, you know, Larry, to your point, how our health is incredibly important, but the, the unintended consequences or the rippling effects are enormous.

Larry

[00:48:09]
You know, we had the, the entire country's attention in the early months. The world. The world. of COVID. Yeah, we have the world's attention and and we have lost that. Um, and you you need that attention once again if you're going to prepare for the next crisis.

Sophie

[00:48:25]
Absolutely. Okay. So we've talked a lot about a lot about, you know, maybe what didn't work, what could work better.

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But I do want to end this this conversation on somewhat of a positive note. So I'm going to ask each of you and we can start with you, Dr Benjamin. But what are your hopes for the future as it relates to COVID 19? health crisis preparedness. I

Dr. Benjamin

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Know. I think that we've learned a lot and I think that we built a lot of infrastructure that will serve us in the future.

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So I'm looking forward and further building on that infrastructure as we go forward.

Estelle:

[00:49:00]
The thing that gives me the most optimism are the people, individual people within organizations, federal government, state, local people like us on this call who really, truly care and want to make a difference. And you see these champions in these organizations pushing the needle, incremental pushes.

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That is what it's going to take. And the pilot program and the equity first vaccination initiative You're seeing it being implemented across the federal government. Now it's, they're not getting the media attention. They're not getting, you know, the kudos or the gold stars, but they are, they're doing the work that's needed to make sure this doesn't happen again.

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And it's really just these, these incremental things that at the end of the day will build up to something greater. And that's what gives me optimism.

Larry

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My hope is that we can rebuild trust in scientific and public health expertise and that our experts can earn that trust by being transparent with the public.

Sophie

[00:50:12]
Great. Thank you. And I think that in closing, my hope is that We can continue these conversations and that people learn and benefit from them. So truly thank you for all the work that you do in your respective spaces. Our country is better because of it. Um, and I really enjoyed talking with you and learning from you today.

Dr. Benjamin

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Dr. Benjamin: Thank you. Thank

Sophie [00:50:32] :
You,

Dr. Benjamin [00:50:33] :
Thank you,

Sophie [00:50:35]
Thank you. Two my three guests, Dr. Georges, Benjamin, Larry Levitt, and Estelle Willie for joining and participating in this lively and impactful conversation.

Tom [00:50:45]
For more on how KPMG is exploring how we can be better prepared for the next health crisis, as well as how we can partner with your federal agency, visit the Framing Health's Future page at visit.

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kpmg. us slash framing health's future.
