Dr. Mitchell Katz: Making a Difference through Health Policy

Event Transcription

USC Bedrosian Center
March 3, 2015
Dr. Mitchell Katz: Making a Difference through Health Policy
USC Bedrosian Center and USC Schaeffer Center for Health Policy and Economics
March 3, 2015

Disclaimer: Please note that the text below may contain transcription errors.

^M00:00:14
>> Raphael Bostic: My name is Raphael Bostic. I'm a professor in the Price School and I am the director of the Bedrosian Center on Public Enterprise. I like to welcome you to the latest in the Quintiles lecture which is not my lecture series but I'm going to introduce you anyway. And I just wanted to say for the Bedrosian Center, and I don't know if many of you have been to our events but, you know, we are a center that focuses on governance and we are really concerned about issues of implementing policies. So, what are the challenges of doing policy once you know what it is you want to do? And as part of our programs, we've tried to--we have a real interest in partnering up with all of the disciplinary fields where there is a lot of expertise on how you design policy to marry the two together. So you have to design it, you have to figure out how to implement it. And we want to make sure that people think about those governance challenges as they design a policy and as they try to do it moving forward. This is one of the reasons why we're really pleased to have Dr. Katz because he's now been doing the implementing of public health policy in two different places that are very different. And for--from our perspective, it's really interesting. I'm really interested to hear the challenges and the comparative approach to that, as well as all the stuff that's changed in health policy. So that's all I'm going to say. I'm going to turn the floor over to John Romley, who will introduce our guest. But thank you all for coming. It's really good to see you and this is a nice turn out.
>> John Romley: Thanks Raphael. So, just by way of a little background in case you're not familiar, I think probably many of you, maybe most of you are. But Dr. Katz has quite an interesting background. Trained at Harvard, was the chief of HIV research at--in San Francisco. Went on to head up the Healthy San Francisco initiative that brought universal healthcare to that location. He's been down at--heading up the LA County Department of Health Services for a while now. And we're just thrilled to have you here. We're glad we finally--
>> Mitchell Katz: Yes.
>> John Romley: --made it all work. And I'm not just saying that because look at--you wouldn't know what the counterfactual is, but this is wonderful.
>> Mitchell Katz: [Inaudible] I'm really happy to see all of you and talk to you about making a difference. I'm a big believer that in whatever you do, there's a tremendous opportunity to make a difference. And what I want to use the time that we have together is to talk about a set of challenges that I faced along the way on where as Raphael was talking, it was clear what the policy goal was. The challenge was how are we going to do it. And that's pretty much how I would frame any problem, once you figure out what it is you want to do, right? So, what is the good thing? What is it you're going to achieve? Then you have--just have to figure out, well, how are you going to do it. And whatever the obstacles are, you have to figure out the plan over the obstacles or through the obstacles or under the obstacles, but that you always keep the goal
in mind. So, this for me was, you know the needle exchange in San Francisco was the single defining event of how, you know, my career was set because it set a tone that I’ve used throughout my career. So, worst years of the epidemic, epicenter of San Francisco, highest per capita infection rate, highest rate of death, AIDS becomes the number one cause of death in men. It's like an unbelievable thing, right? Over night, right? No longer heart disease, not cancer, but AIDS, right? Very poor treatments, prevention somewhat effective in--when you can get people to practice safer sex, use condoms, but huge problems with needle users, right. So people exchange needles then they become infected, huge problem especially because people were using needles then they were infecting their sexual partners. So people who were not using needles were getting infected. Babies were being born with HIV infection. And we had a common sense prevention which was clean needles. And in fact, at the time, there was quite clear evidence that in those places, like mostly west European cities at that time that had needle exchange programs, infection rates were very low. And in places like New York City, Newark, Miami where there were no needle exchange programs, infection rates were very high. The challenge for me was, so I--we had in San Francisco one of the early renegade needle exchange programs, grassroots which is often the best way that anything happens. People come together, distribute needles. But the problem was that the demand for the program was so great they couldn’t fund the needles anymore. There's just too many people wanting clean needles. And because California law said that syringes can only be dispensed with a doctor's prescription, there wasn't any public funding possible for needle exchange because obviously needle exchange didn't operate with prescriptions. And it wasn't even possible for them to fund themselves as philanthropic money, donations, I mean, well, people could donate but it couldn't be tax deductible because it's an illegal activity. So, it had a huge problem raising money for needles. So what do you do? OK. You ask yourself, "OK, so needle exchange is technically speaking illegal. Is there any countervailing law that you can find that might help you to make needle exchange happen, right?" That is to say if one law says you can't do this but another law says you must do this, then sometimes you can make something happen. And so, what we discovered looking very hard, we couldn't get around the fact that it took a prescription to dispense needles, but state law allows counties to suspend laws in cases of public health emergencies. Ah, public health emergency. Well, this is a public health emergency, right? AIDS is now the number one killer among men in the city. I have a--it's an infectious disease. I have a method of preventing it. Let's declare a health emergency. So we--the board declared a public health emergency. The mayor signed the bill, even though the county council at the time advised him that, A, he could get arrested, and B, what's even worse for politician is he could be barred from running for any future office. So--But nonetheless, you know, we had a huge grassroots support for this and he signed the bill, needle exchange was funded. Just to show how ludicrous this was, we had to renew the public health emergency every two weeks for nine years. So, I ask you what kind of public health emergency could exist for nine years continuously, right? At some point clearly it's not an emergency. It might be a huge problem but hard to argue that you could have an emergency for nine years. But, it provided the roost, the frame, whatever you want to think about it, the countervailing law that allowed 2 million needles to be exchanged dirty needles for 2 million clean needles. It not only prevented HIV but hepatitis B, and now we would recognize also hepatitis C. At that time, the hepatitis C wasn't
even yet defined. It was just called 'non-A, non-B hepatitis and the tremendous death rate due to hepatitis C wasn't appreciated. So, we did a lot of good. In 1999--I remember, I did that 1992. 1999, the states passed a law allowing counties to establish the needle exchange programs but only if they declared an emergency. So they actually stole our line, right? So, they couldn't get themselves in 1999 to say, "OK, you can use public money for needles." But they got as far as saying, "OK, well if you're a county and you declare an emergency--" So now we had, I think it was four of the counties every two weeks declaring a public health emergency year by year by year. 2011, California passed the law that allowed needle exchange programs to be funded without an emergency order. Unless you think that this is some, you know, prehistoric story that has no relevance, you cannot fund today needle exchange with a federal dollar. Federal dollars for HIV prevention cannot be used for needle exchange, even though needle exchange is a known effective HIV prevention strategy.

They briefly allowed funding in 19--in 2009 so, that would be 17 years after we did needle exchange, but Congress reinstated the ban in 2011. So meanwhile, San Francisco continues to exchange needles and we not only save lives by doing that but we taught California how to do it in other counties. So, I now use that and--I mean, one of the funny ways that my San Francisco experience has helped me throughout my career is, so someone comes and tells you that something is illegal. I'm like, "OK, how else could we do it, right?" I don't--it's just--I'm not interested. I mean, I understand that, you know, we can't do things just that are illegal without coming up with at least another law or a way around it, but I'm not moved just because you tell me that something good is illegal. I'm not going to just back off. So I want to--Here are some other examples of how you might look for another way to do it. So, let's move a little bit from an HIV to a sexually transmitted disease clinic, and tell you about a pressing problem we had which is that women would come in for STD diagnosis and treatment, and they would have tremendous trouble getting their partners to come in. The male partners were very reluctant to come in. And so what would happen to the women is they get re-infected, right? So you would treat them for the infection, but if the partner doesn't get treated, right, then they're going to keep getting re-infected. What had been done unofficially is in many private gynecologist office, a gynecologist will just give a woman a prescription for her partner. And of course, this can go the other way. You could have a male partner whose woman partner wouldn't come in. It goes either way but epidemiologically it was mostly the women partners who couldn't get their male partners to come in. But technically speaking, the California Medical Practices Act forbids the prescription of antibiotics by a physician without examining the patient. So, while, a gynecologist could do that on their own, I'm running a large county system. I can't actually, without coming up with something else. I can't just send a letter to all my doctors saying, "Please act counter to the California Medical Practices Act. And I want you for the good of these women, I want you to send home a prescription for their partners." I can't do that, right? I can't just by saying, you know, I want you to do this for that to happen. But, OK, so let's go for--do we have a countervailing rule? So, Health and Safety Code also authorizes the local health officer to take all necessary measures to prevent the transmission of infectious diseases. Oh, this is an infectious disease and I could prevent the transmission of those infectious diseases, so maybe I do have a way of having my providers do this. So, I changed the policy. I wrote a letter to all my clinicians. So I just go back and said, "California Health and Safety Code
authorizes the county local health officer, blah, blah, to take all necessary measures. As your local county health officer, I am authorizing you to send home prescriptions for men and women to give to their partners to take.” And the physicians then felt comfortable, well, after all their director had done it. Go ahead.

>> What fraction of physicians do you think read those? When--

>> Mitchell Katz: They almost--well, I wrote the memo so that nobody would feel that they were taking on the limb. I actually talked with all the [inaudible]. The STD clinic is--so this is specific to the county clinic, right? I didn’t try to organize all of the doctors, because you’re right, that would have been very different thing. I’m in a small clinic but it’s a categorical clinic and it’s doing almost all the STD care or a lot of it in the county. So, because I’m always interested in not just how you fix something but how you fix it in a way that makes everybody’s lives better, not just the people you directly touch, I wanted to have some data. And this gets into an interesting question where I often argue with academics about the question of data. So, there is the data that’s necessary for you to feel that drug A is better than drug B, and that, you know, needs to be really rigorous data because it’s easy to confuse the effects of drugs and drugs can have side effects. The level of data that I need in order to make policy change is very different. The people I’m working with are not reading the New England Journal of Medicine. They’re not asking whether or not in the randomized trial everybody was blinded to their drug assignment. The world doesn't work that way. Most the things I do were not subject to randomization. But what policymakers do look for is what's the evidence. Show me the evidence. But they don't always have the same ideas of what evidence might be. And so, the argument that sometimes comes to the researchers has to do with rigor, right? You know, they say, "But isn't it important to have the most rigorous design possible?" And I say, "Isn't what matters whether or not you get the policy change that you want the policy change." So in this case, here is an incredibly weak study. We surveyed STD clinics who received partner packets. In 73% of the patients [inaudible]--yes, 73% of the patients said that their partners took treatment. And we said, "Gee, that's a lot higher than our experiences." And the 57% then discussed STDs, and we said, "That's not what we think generally happens." That was our only "evidence" of the success of our practice. On the basis of that and on the theory, I got the San Francisco Medical Society to vote to support partner treatment. And the reason I asked them, which again, is here one of the little secrets is coalition building. How do you build coalitions? Well, the first thing you do is you go to who's the easiest group to get, right? You don't start if you have an initiative like this. I wouldn't start with the American AMA, which is a very conservative private doctor group. I started with the San Francisco Medical Society which of course I'm a member of, and has more of the values of San Francisco, and they supported the partner treatment. And then, the California Medical Association which is somewhere on the spectrum sort of between the San Francisco Medical Society and the American Medical Association, I knew that if I just brought to them the idea, they would say no. But, if I brought them the idea as passed by their affiliate, the San Francisco Medical Society, they would be inclined to do it because their whole structure is about affiliate, so all the affiliates come to the state meeting, just like then all the states go to the national meeting. So, they approved it by only one vote with a lot of concerns being raised about, well, how do we know what's going to happen, and what if someone gets an adverse reaction, and all of perfectly reasonable things, but things that are not as important is whether or

Transcript: Dr. Mitchell Katz: Making a Difference through Health Policy

USC Bedrosian Center | 4
not the partner gets treated for the STD. So, it won by only one vote, but of course that doesn't matter, right? When you're getting endorsements, you just needed an endorsement. Nobody knows when you go to lobby as we did when we had this Senate Bill 648, 2001, I got to put all over it that it was endorsed by the California Medical Association. I didn't have to say, "Parenthesis, you should know that I only won that by one vote and that was only because I did it through the affiliate of San Francisco." Well, I just said, "California Medical Association supports this." Even so, I only got chlamydia. The state legislators red lined out gonorrhea. They did not authorize the prescription of medicines for gonorrhea. Legislators don't like to talk about gonorrhea. Gonorrhea has a different socioeconomic status, epidemiology and chlamydia. Chlamydia is more of a middleclass disease. People understood chlamydia. They understood the possibility that their children or grandchildren might get chlamydia, their daughters, their granddaughters be infertile, not produce grandchildren. People understood chlamydia. People were reluctant to pass a bill about gonorrhea, so it got red lined out. Did I say when they red lined out, you know, did I go and march and say—and say, "You know, this is terrible. You know, I won't accept this bill you know, if you don't put back gonorrhea." No. ^M00:20:09 I said, "You know, thank you very much," because what I thought is—I'll come back at them, right. Let me—if this is what they are comfortable with, I was still doing what we were doing based on our local, you know, let me get the bill I can get. And then five years later, we got us Assembly Bill 2280 which authorize patient delivered therapy to partners with gonorrhea or other STDs. So, we got it brought in four year--five years later. I had to wait a little bit but it happened and this remains of course the law in California. And then, sometime later, 2005, a study comes out still not exactly the question because this was expedited treatment versus standard treatment. But it showed that when you gave people expedited treatment, the chance of recurrence of an STD was lower. So, basically proved—we ultimately proved the point. But this has happened a lot of times in my career. The proof that it worked occurred after I got the change. Not necessarily before I got the change. HIV testing, they remain in this country's substantial numbers of people who are infected but don't know they're infected. There are lots of barriers to testing. People are in denial. People are frightened. People don't know they're at risk. Lots of barriers that are hard to change but change the ones you can. So, one of the ones that I had thought a lot about as a clinician was the written consent for HIV testing. So, at the time, the standard, and this isn't in the 2000, was if you're going to get an HIV test you have to do a written consent. And the reason that this discouraged people from testing and I don't know how many of you have ever been in a hospital, have been with someone in the hospital or exam room, doctors are not necessarily great communicators, right. And often they say, "Oh, you know, please go for this lab test." And people don't know what lab test they're actually getting. They're often frightened that how many tubes of blood are removed from them. But if you imagine under that paradigm and then somebody says to you, "I want to do a blood test. But before I can do this blood test, I need you to sign a consent," right. You're in a hospital, maybe someone is trying to diagnose a condition that's so far been undiagnosed. You're a member of a disenfranchised community, you're gay, you're an injection drug user, you're African-American, you're a Latino. Nobody seems to know what's wrong with you. They've been doing all of these tests and no one has asked your permission. And all of a sudden someone comes into the room and says, "Before I do this test, I need you to sign this form."
Wouldn't you be suspicious about why it is that they've just been drawing all this blood from you without any consent and all of a sudden someone is showing you a consent? I think I would under those circumstances. I think I would ask myself, you know, maybe there's a reason that they have a consent attached to this and maybe I don't want this particular test. Not to mention that hospitals being what hospitals are, half the time the test wasn't done because the resident in the hospital forgot the test had, this form had to be signed, and the blood was drawn but it went to the lab without the form, and the specimen got thrown out and meanwhile the person was discharged, and all the other things. So I started looking at this written consent issue, and I discovered and I have to say I was surprised as someone who'd grown up in the era, that there was nothing in the law requiring a written consent. What the law said was that people had to be consented in order to give, to get HIV test. A very sensible requirement especially in the era when the test could result in you being discriminated against for insurance and there was no obvious benefit necessarily of knowing because there wasn't very good treatment at this time. So when that original law was passed, that made sense. It was the hospital lawyers who added the written consent. The law didn't say written consent, but the hospital lawyers, when they read this immediately, right, lawyers are always risk-averse. I don't know how many of you are or want to be lawyers, but lawyers tend to be risk-averse, right. Their job—you're a hospital lawyer, your job is not the same as my job, even though we might both work for the hospital. My job is to, you know, promote health, right. So if somebody is HIV positive and I need them to know in an era because by now great treatment is available, the ability to prevent transmission to the fetus is available, right. It makes a big difference by this time when I'm working on the issue, so I really want to know. Hospital lawyers, their job is to protect the hospital and the doctors from being sued. So they had put in the written consent because their question was, "Well, how would we know if the patient consented unless the patients signed the form?" So we said, "Ah, well now that we see that, we're going to abolish the written consent form and clinicians need to note in the chart that they consented the patient as you should do for any test." So, clinicians consented the patients, we eliminated the written form, and in a time series, the latter part is what happened. All of a sudden the elimination of a simple form resulted in more people getting tested. And although I didn't bring the data, it wasn't just healthy negatives. There were more new positives found. So, that simple change—and then OK, so with that experience and the same idea that you want to make change and make things better not just for the people you serve but for everyone, we changed the standard to right to decline. So, the people now, the modern standard which fits the risks and benefits of the test which are very different than the risks and benefits when the test was first created now say that as a provider when I test someone, what I say is, "And I'd like to test you for HIV because you've had sexual risks and this could explain the symptoms you have. Is that OK with you?" They have the right to say, "No, I don't want to be tested for HIV," in which case I wouldn't do the test, but it's no longer a, "Can I consent you?" It's more in keeping now with how I would introduce other test. So that is the law for HIV. Tobacco, number one cause of preventable death, still. San Francisco became the first locality that banned pharmacies from selling tobacco. I felt—to me this was a personal issue that came up in part because my daughter has asthma. And so, I was going to a local pharmacy, and I'm just sort of standing there and I'm about to pay for her asthma inhaler and I'm staring at a wall of cigarettes. Thinking, "God, that seems really wrong".
Have this big sign, you know, about, you know, "Walgreens is your health provider," you know, I'm like, "Well, if you're my health provider, what are you doing selling the tobacco? And what about the conflict of interest here? You're--the more tobacco you sell, the more of these inhalers you're going to sell." It doesn't seem quite right. And what would be the message if the, you know, if you believe and as I do that, you know, social messages matter, right. You're, you know, 19-year-old. You walk in under the sign that says, "Walgreens cares about your health," and there's all the tobacco, right. What kind of message does that send? So, we--I guess I didn't bring the--who else did it. So, after we did it, Boston did it. Several counties in Massachusetts did it. Another city in California did it. And then CVS agreed to stop selling it. And we're still working on some of the other big providers.

>> Can I ask you, what fraction of cigarette sales are at pharmacies prior to this?

>> Mitchell Katz: In San Francisco--I'm trying to think if we were ever able, we were not ever able to figure that out because it's retail data and no one wanted to give us retail data. What I did check, because the pharmacies complaining that it was unfair to them. I checked that after a few years after the ban, there were actually more commercial pharmacies in San Francisco than before the ban. So, it could not have been so important to their economic bottom line. They survived. Health care coverage, we're now--we're at 2008. In San Francisco, Clinton's bill had failed.

^M00:30:06 Governor Schwarzenegger came within one vote of passing for California a health reform that was very similar to what had been done in Massachusetts, employer-based. And we're like, "OK, San Francisco, you know, has always been on the forefront, we want to have universal healthcare coverage." So, we created Healthy San Francisco, which is the only still coverage initiative that provides health services to the uninsured regardless of income, immigration, or pre-existing conditions. So I'll come back and talk about a--I now have a program in Los Angeles that is regardless of immigration or pre-existing conditions but only takes care of the lowest income people. San Francisco's was truly a, oh, everybody welcome, you know, people pay based on their income but it was not limited to low-income people. It provided a standard benefit package even though it was not insurance. It was coverage with services provided by a network of providers in San Francisco. Worked very well. We found an independent group did a satisfaction survey, found 94% of enrollees were satisfied, 92 recommends a friend, and 41% reported that their health needs were better met than before the program even though people would generally go to the same providers they were going before, because all it was, was knitting together the existing providers in San Francisco. All of them had their own individual program and we turned it into a comprehensive program by putting together the outpatient clinic, the hospital, the pharmacy, and sort of branding it and giving people a card and helping people understand what the cost were. But generally, they were going to same places they were going before and yet they were more satisfied. They were more likely with Healthy San Francisco to have a usual source of care. They were more likely to use outpatients than the uninsured group were. We found less inappropriate emergency department use. It was copied by Howard County, Obama in the midst of the Healthy San--the debate for ObamaCare shouted out to Mayor Newsom if San Francisco could do health reform surely the nation could do it. So the one problem, which I am telling you at the end but I was told at the beginning was it's illegal. You'll never get this through court. The smartest lawyers
said ultimately, the model of Healthy San Francisco which persists today could never survive a court challenge, and you will be sued and you will lose. What were they talking about? Well, we're not getting into--or I'll give you just enough so you can understand because it is a fascinating story about how you get stuff done even in the face of things being "illegal." There was a law passed in the '30s called ERISA. ERISA was a law that was really not targeted about health care. It was a law the country is growing at this time and you're getting all of these multi-state companies, you know, the forerunners of groups like McDonald's, or Target, or Walmart. And sensibly, these companies, they don't want to have to deal with every tiny county cities requirements of what their employee benefit packages should be, right. So that makes sense, right? You know, you want to spread. You don't want companies to have to deal with, you know, this one says the deductible can't be more than 200, this one says the deductible can be 300 but the co-pay can't be more than 5 [inaudible]. You'd go crazy. So they passed this law that basically said that you could not impose benefit on benefit requirements on businesses. And so, this is what made it really hard to do any kind of local program because if you wanted something employer-based, it wasn't clear if you were not, you know, at the state level, how you were going to do it. So, we got challenged by the Restaurant Association. Why the Restaurant Association? Because they had the largest concentration of workers that were uninsured of any businesses, right? That's historic. Retail, your average Macy's worker is insured, your average waiter, this is previous to ObamaCare, uninsured. They just had a lot of people to do it. So, they--we prevailed in the Ninth Circuit which is a very liberal court, but we prevailed again not just because it was a liberal court but because we had created a reason for them to exempt us. The Healthy San Francisco was not an insurance product specifically so we could argue that well since we're not an insurance product, we are clearly not covered by ERISA. ERISA--it's not an ERISA health plan. It's not a health plan that is registered as an ERISA product. And that would work in a court that was, you know, on the liberal side of these kinds of issues. We knew if we got to the Supreme Court, we would lose. So, if you know that, then what do you have to do? You have to convince the Supreme Court not to take the case, right? You know what's going to happen if they take the case. But do--can you convince them remembering that courts, right, up into the Supreme Court, they have to hear it. Supreme Court does not have to hear a case. So, we prevailed on them. We got for one thing, we got the Obama's labor secretary to put an opinion that it was not conflictual. And then we wrote a brief that was all about why they shouldn't take the case, citing the fact that this was a small county, that health reform was going forward in the country as a whole which would make this small program irrelevant, and that there was no need for them to take the case. And they never took the case, and Healthy San Francisco proceeds. So, just again, just because a--well first, it illustrates, and I didn't put the first court that heard it before the Court of Appeals, the district court voted it out. We appealed then to the Court of Appeals and they were the ones who said we could keep going. So, that's another general point about these things is when a lawyer tells you passionately that this is not legal, you have to remember that nobody really knows what's legal in most cases of these kinds of issues, and we know murder is illegal. But one court said it was illegal and the next court said it was legal, and if the Supreme Court had heard it, they would have said it was illegal, right? I mean, they're--and they were all looking at the same laws, right? They're all inferring what a congressional ERISA law passed in the '30s means about a universal health coverage
product that is not insurance in San Francisco means in 2008, right? And so, there's room for disagreement.

>> [Inaudible] debate on what--whether that universal health coverage was actually a health plan?

>> Mitchell Katz: No. Truly no. Well, not at the--the Ninth Circuit bought that it was not but actually I think that the district court said sort of looks like a duck quacks like a duck.

>> Yeah.

>> Mitchell Katz: Right. Well, that's the argument.

>> So, what's your definition of that why it's not?

>> Mitchell Katz: So our reason for why it was not an insurance plan was that it was not--it had no coverage outside of San Francisco. So, unlike most plans, right, where you have coverage, right, if you travel, this was truly a local plan. It was unregulated by the state. So those were--Oh, and the--we also--I didn't again, you know, I won't spend too much on the details although they're fascinating. The actual law that was challenged was not Healthy San Francisco because it couldn't--Healthy San Francisco was a feature of the law. The law was an employer spending mandate. It's said that each every employer in the city and county of San Francisco had to spend a certain amount per employee work hour on health benefits. And they could spend that money by setting up a health savings account, by paying bills, however they want it, by buying an ERISA insurance plan, or by contributing to Healthy San Francisco.

^M00:40:10 And so we argued, you see that we're not dictating anything. It's nothing about benefit packages. All the city and county is saying is that each business must spend this amount of money. But district court said it looks like a duck quacks like a duck, as best as I remember. OK. So, coming into today's time, so Los Angeles, largest--second largest safety net system in the country, 4 hospitals, 2 former hospitals, 15 large community centers, many small clinics, 700,000 unduplicated clients a year. So I came at 2011, which is sort of the dawning of health reform which, you know, their Medicaid expansion went into effect one year ago. And the problem is that expansions have historically been disastrous for LA and the public sector. So when Medicare was promulgated in the '60s, all the seniors left. They just left. They got better. They had other options, "We're out of here."

>> Right.

>> Mitchell Katz: Right. We're not at LAC. We're not at Harbor. We're out of here and we're going to a private hospital--

>> That just speaks to quality, right?

>> Mitchell Katz: Absolutely. Medicaid, same thing. Pregnant women get Medicaid, they leave. "Oh, I have other choices. I can have my baby at Cedars now. Bye." And survey done at the time I came by Blue Shield showed that among low-income Californians, 67% of those with no choice said that they wanted to change their current provider. So, two-thirds of people are saying, "When I have my choice, I'm leaving. I'm leaving the public." They weren't just talking about us but that surely we were among the public providers.

>> Two-thirds of USC employers may say the same thing--

^M00:42:13

[ Laughter ]

^M00:42:14
Mitchell Katz: Could be, could be true. So, that's the challenge. And just to say a little bit more about why that's an important challenge, Health reform and what Obama got passed in my opinion is a really good thing, but it does not include undocumented people or million undocumented people in Los Angeles. If this is relevant because if what you imagine is everybody has coverage, so there aren't--nobody has left out, then you could argue if the public sector doesn't survive, OK, maybe the public sector shouldn't survive, right? If this public sector cannot deliver quality care and other people can deliver quality care at the same or lower costs, so be it. What's the harm? Well, the harm is in this county who's going to take care of all the people who are left out, right? If all of the paying people go somewhere else, how do you sustain the system for those people who have no place else to go? And keep in mind that hospitals have huge fixed expenses. The place like LAC+USC, if I had half the beds filled, I wouldn't have half the expense. I probably have about 80% of the expense. So some of my expenses are variable, things like nurse staffing, but a lot of my expenses keep going, equipments, utilities, medical staff, emergency department, ORs whether I'm 100% full or 60% full. So, what did we do? We set to say, what I believe, and I'm a public sector guy, I believe that the public sector can be as good as the private sector. We have different pluses, we have different minuses, but overall I believe we can deliver high quality care. But we have to set that as a goal, right? We can't just say, we--you know, and like the old Lily Tomlin, you know, we're the phone company, we don't care, we don't have to, right? If that's your view, right, you're not going to be a high quality provider. You have to decide that your future is necessary to be--you have to deliver high quality care or you'll have no future. So we enrolled a large number of people into the Bridge to Medicaid, so that they would get Medicaid on the first day. We started empanelling people, meaning that people would see the same providers over and over again, which in LA was an unknown thing in the public sector. If you came one week, you saw Dr. A. You came back four weeks later, you saw Dr. B. And everybody accepted that there was no, you know, Dr. B is your doctor and she will see you, you know, from now on whenever you go, right? Well, what is it that builds loyalty, if you do surveys of any population including of USC employees and you ask them about their insurance plans, what's important to them, the number one thing people consistently say is "My relationship with my doctor." That is the number one thing. Of interest number two is parking [inaudible]. People want to see their doctor and they want to be able to park conveniently. They don't want to, you know, have to drive round and round looking for a parking space. We are successfully implementing an electronic health record and a specialty referral system proving the patient experience. One of the big problems was unacceptably long wait times for specialty care. And we fixed that by creating eConsults which enable a primary care doctor like me to send a consultation to a specialist and then get a response. So, no longer do I schedule an appointment. One of the things that has made this work so well is often a person doesn't actually need an appointment. They need advice. So, I might have a patient with bad heart disease and what I need to know is what's the next medicine to try. In the old days, on our system that would mean having to schedule a cardiology appointment. Now, I can send a consult to a real cardiologist. He or she can see the EKG, can see the echocardiogram, can see the medicines I've already tried and make a recommendation, and it's done a huge amount to decrease our wait times. And skip this. And then one more example, very similar, we had a huge wait time for eye exams. So we instituted
these cameras that people can do in their office to take a picture of somebody's retina. And it turns out there's a huge in Los Angeles because we have epidemic of diabetes. And all of the diabetics is supposed to have their eyes examined yearly, but we don't have enough ophthalmologists to do that, even if everybody were willing to go. But by instituting these cameras which we can do, you could--I could teach any of you in about 20 minutes how to take a picture of somebody's retina, very simple camera technology. Then the images are read. And then the important part, they're only read as in normal or need to be--have a referral. And 66% are read as normal which is a huge victory because it means 66% of the people don't need to visit. We're done. So, I was able to go from the system where, you know, I couldn't have enough eye appointments to making eye appointments unnecessary for two-thirds of the people better for them, better for the system. And now, I have enough ophthalmologists to see the people who have retinal disease. And there are many more type things. I just wanted to bring this as an example. I was in--these are my kids. Both of them I adopted from an orphanage in Vietnam as a way of saying, "You know in life there are lots of ways to make a difference and it's not just that work lives where we make a difference." I'm a big believer that you make a difference when you're a good parent, when you're a good son, when you're a good daughter, when you're a good friend, when you, you know, help out other people, right. But that--that the goal of life especially for people like you, you know, who are privileged by being smart and getting great education and, you know, having your lives together, then, you know, the goal is well, you know, how do we make a difference for people whose lives are not so together and what's, you know, what's our, you know, common responsibility, you know, to everybody else as a way of appreciating, you know, the luck we've had to lend what we have in your case and, you know, this great school. And you know, and in my case, you know, to have--you know, what luck I have to have such an interesting career and where I get to make a difference. Important to me to, you know, always keep in mind that doing my best to try to make that difference. So, I think we have a--I wasn't watching a clock. What time is it, Raphael? How are we--

>> Raphael Bostic: 2:55.

>> Mitchell Katz: 2:55, good. Because I'd be more interested, there are lots of other things to talk about. More interesting to--for people to ask questions or they don't have to be questions. They can be your own views of these things, or suggestions or what you know about the system.

>> Thank you.

>> Mitchell Katz: Thank you. I appreciate that. Thank you. All right, you're going to lead us off?

>> The downside potentially from the justice of the Affordable Care Act. Have you seen people--obviously you've got more people potentially coming in. The people who got more options and went elsewhere, have you seen that at all in your data?

^M00:50:07

>> Mitchell Katz: So, so far what the data show is that we're retaining our population, but I don't believe that if we hadn't done what we did that would be true. So, in other words, if we hadn't impanelled people, I believe we would have lost them. The game though is not over, and the reason it's not over is that initially, the way--we had done a very smart thing, we had enrolled all these people into a precursor program. So when they came time for Medicaid, they naturally rolled into us because they had--the state used an algorithm that was based on where you had
last received care. So when they couldn't go anywhere, we made a big effort to get them to us. Now, when the algorithm gets turned on last January, they all rolled to us because what the computer files shows is that their last provider was us. It takes some time for people to figure out exactly what their choices are and to see to compare their experiences with those of their friends. So, we haven't had the drop off. But I'm still conscious that it could turn--we could seep out if people feel that, "Gee, I could get that done faster, you know, somewhere else. So, that's why I spend a lot of time on, you know, things as basic as the phone system. You know, I mean to me, that's like a high--you know, that's, you know, a high priority issue, does someone answer the phone when you call? And when I got to LA, I started--I'm a very sort of hands-on person. It's the only way I can figure out what works or not. So, I go look on the web. Well, I look up Los Angeles Department of Health Services. So, I look on the web and what I try to figure out, "OK, how many patients I want to go for services? What do I do?" So, you know, this very convoluted, hard to figure out, eventually I find some phone numbers that are on the web. So I say to one of my new staff, "I'd like you to figure out how to make the website more friendly." He says--He's really good staff member, he says, "I'm going to do that." He comes back the next day and says, "Well, worse than you thought. You know those phone numbers?" I said, "Yeah, they're the only way I could figure out how you would get into the system." He said, "They're all disconnected." Imagine the message there, right? You--After struggling with the website to see how, you know, find there, because they didn't--it's not like they put it right at the top call, right? You like had to go to multiple screens to try to figure out. It was clearly designed by someone who didn't want you to call, right? But when I finally found the numbers, they're disconnected. So, you know, very--if you can't figure out who to call, right, big problem. Please?

>> People leave the DHS. What are their options and how does quality of care at DHS compared to those [inaudible]?

>> Mitchell Katz: So, in LA, there are options of every type. So there are small practices like they're in the industry referred to as onesie-twosies, you know, one doctor, two doctors in an office. There are federally qualified health centers, say, St. John, Saban, Venice. There are some of the hospitals have outpatient clinics that take care of people with Medicaid, not all, so not so much--well, USC for example at this--at the university campus, I don't think they have much primary care. But other hospitals like White Memorial do. So, there are a variety of other choices that people could have. But it is true people tend at least initially to go where they've gone and it's only if what they hear, what would kill me is if people got experiences way better. I think what most people would say on the quality issues is DHS probably by most standards provides higher quality medical care by most criteria which is to say, we have more board-certified physicians than most places do. We have a higher--every group uses nurse practitioners and other midlevel such as physician assistants and doctors, but we tend to be more doctors, fewer mid-levels and then the other providers more mid-levels, fewer doctors. So, we have very strong academic affiliations with USC and UCLA and in general academic medical centers provide better care. The problem we've had is that you can't get in, you can't figure out how to get in, the phones--you know, the phone number doesn't work, there is no--you call--you [inaudible], you get in and they say there are no appointments. They treat you rudely. So the issue historically of the county has been that once you got in, you've got really good
medical care. So my job has been which in some ways an easy job and I think has been mostly successfully. Gee, if you can get the medical care, right, which is the hard part, surely you can get the customer service right, right. That's not that hard, right? Nordstroms [assumed spelling] knows how to do it, right? If Nordstroms can do it, it's the same principles. It's really not very hard. I mean, we--you know, patients are not so demanding of, you know, fancy lighting and fancy carpet, but they do know whether or not the people care about them or don't care about them. And if nobody says hello and nobody says welcome and people make you feel like they wish you weren't there, you're going to look for a different place.

>> So, I was very surprised to see these innovations with trying to reduce the shortage of specialty care, and one of the things that have been talked about a lot is the shortage of primary care physicians, and in particular with Medicare and sort of the poor population and that's part of the problem with what happens when you have universal coverage is you have more people who want care now but not enough physicians to provide it. And so, one of the solutions is to pay physicians more to see this particular type of population. Do you have a sense of how California either structured its Medicaid payments or why they change or whether there's any discussion over changing how we pay physicians to ensure their care?

>> Mitchell Katz: Sure. Well, it is as you allude to, it's a complicated issue. So, let's, you know, just to be provocative, you want more primary care physicians? Pay primary care physicians what you pay anesthesiologists and pay anesthesiologists what you pay primary care physicians and see what happens to physician supply for primary care and anesthesiology. And I use that example deliberately because, well, there are disparities all over. So I'm a primary care trained physician. A close friend of mine who trained at the same time, she's a neurosurgeon. I understand why she should earn a great deal more than I earn, right? I trained three years, she trained nine years. A lot of the time I spend in the office, you know, talking to people, she does this microsurgery with these procedures that last like 11 hours which she's picking the tumor of people's spinal cord, right? She should earn more. That's a really hard job for which she trained and gave up income, right? I was working getting a living for six years during which she was still in school. Anesthesiology is about the same length of the training as I do, right? Same with some of the other radiology, dermatology, emergency--but we've just decided that we--because of our love of specialty care or some of the dynamics in professional medicine, to pay people more for these areas. So, if it's going to change, it doesn't need to be some differences in what people overall earn. They're--Nobody is against spending more money on primary care doctors, except that everybody wants health care to cost less. And health care if you look at the GNP and what we get for it in this country, it should cost less. We're certainly not getting the outcomes that Western Europe gets with lower cost. Western Europe by the way, the biggest, you know, difference between doctors in Western Europe and us is in Western Europe it's two-thirds primary care, one-third specialty care. And in the US it's two-third specialist, one-third primary care. It's probably is why we spend more and get worst outcomes. So, you know, whether there is movement to increase primary care specialist salaries but a lot of resistance to lower and specialty care salaries. And it's unclear how ultimately you make the money work. A lot of the effort is going right now to the question of can you--can people other than doctors do primary care. And the answer of nurse practitioner, physician assistant is not such a satisfying answer because the price differential is not so great.
A nurse practitioner might earn 110. A starting primary care doctor might earn 160. That's not a huge difference compared to say an anesthesiologist is earning 450 or 500,000. So a lot of the movement is around can other people do some of the work of primary care? And I think they can. You know, can you help coaches, right, case managers. Certainly a lot of what any primary care doctor does is other than treat and diagnose illness. So, that's a lot of work in that area. Go ahead.

I think that your—I was very inspired by the way that you presented these laws that are barriers to actually getting better performing health systems. And one of them that I struggle with right now are laws that prevent efficient research use data. And I'm wondering if you could tell a story like this that says, "OK, like we started it in 2015 and it cost USC $120,000 to broker or governance agreement between CHLA and the DHS to try to get efficient research use of data". And that is based on trying to work around some legal systems that allow research use of data to be subject to a complete different structure than quality improvement and in public health. And there's people in this room that could get—putting their brains on that problem a better use of the data in these health systems to deliver value-based care or have the barriers and accessing that. How would you tell that story for making it much more efficient?

Mitchell Katz: Well, so that's a great—that's great question. Try to think of who's in favor, who's against. So—and what are the banners. I'm a big believer in banners. Banners or how you package the thing that you're doing so that people want to follow you and that's why I think of it as a banner, right, because it's the thing that's in front and what you're trying to imagine is—and you might [inaudible]—while I'm talking thinking about what you think the right banner is. But that would be my—one of the first things I’d be thinking about is, what does that banner say. And I will tell you that the first thing you have to figure your way around is that unfortunately, the other side has won this argument and their banner is confidentiality. Who's against that? So that's a very good banner for all of these dumb laws that really don't protect anybody, and everybody knows everything about us anyway, right? So—But if you—if the people you're working against, they're successful and they have been, and they have branded this issue as confidentiality. And if a lawmaker is looking at what you're trying to do and someone over here is putting in his or her face the big sign confidentiality, they're going to be on that side because nobody's against confidentiality, nor you. But—So, you know, what I would be thinking about is, "OK, well, what would be my banner on the other side and who would I get, who would be willing to stand with me?" So even on the cost my first question would be, "OK, well who's paying that money?" And now the people who are paying that money, are they powerful people? Does the average elected official care about that constituency? Who cares about that constituency? What influence is that? So, every public policy thing that I've ever done involves empowering your friends and neutralizing your enemies, right? And, you know, you can play that on the very local level which is where, you know, a particular let's say political leader or community leaders against something that I'm doing. Maybe I can't easily change their mind but maybe I know somebody who can change their mind, right. So maybe I can figure out who is a friend of the person who’s against me and get them to change their mind. Or maybe when I'm most successful I'll reframe it so they think that, that they do support it, right. So I don't know enough about your issue, but I would say it sounds like a great issue to work on. It would help certainly if people could see, and I think this is a little bit of the black box of big data, is what
they're going to get out of it. It may be another challenge you have is that outside of the academic community, people are not sufficiently convinced of the value of using these datasets to answer questions. So they don't see it. They're more thinking about, you know, like here, you know there's a serious movement if you're talking about banners. It's very likely that Congress is going to pass a right to unapproved treatment. Why? Great banner, right. So, do you know anything about the right to unapproved treatment? That's basically whereby, you know, a company is developing a drug, it isn't yet to market, but it's known about in the research community. Someone has X awful disease. They're going to die anyway. Family learns company X is producing this drug but the drug is not FDA approved. So, politicians are very fast to want to line up for that. Why? Because it sounds—it sort of sounds right, right? You know this person is going to die, what would be the possible harm of giving them that drug? That's a good banner. Whether it's good policy or not, I'm not so sure, but it's a good banner. This problem needs a better banner.

>> Can you speak briefly on DHS's strategies for addressing the homeless population, specifically any preliminary results from the Housing for Health program?

>> Mitchell Katz: Well, I'll—you know, I'll start, and thanks for the plug, by saying that from my point of view, homelessness is a completely curable condition. And I had distinguished that from many things people have that I take care of, people who have awful cancer, can't do much about it, who have end-stage heart disease, can't do much about it. Substance abuse, sometimes is, you know, from, you know, the stories that hit the newspaper about famous celebrities, the best of treatment. People, you know, continue to use. Homelessness, I can cure that. You can cure that. Our programs cure that, right. We have—in terms of outcome data, we have for the Housing for Health program, we have 90% retention rates at one year of people who are put directly from the street or the hospital into housing. We've completely, you know, blown the old paradigm up. That could have been a different example, all right? And it's a good—it's a different kind of example, it's an example of where smarter—a smarter idea is the solution. So when I was a resident, the way you dealt with people who are homeless was called the Continuum of Care. And the Continuum of Care said, "The first thing you do is you develop a relationship with a homeless person through an outreach worker, you try to get them to primary care if necessary, you take the vans and you go around and find them, you encourage them to go into shelter, the shelter they give information, they get referrals. First order of business is getting them to stop using. There was a belief you couldn't even evaluate people from mental illness until they were off alcohol because alcohol can in fact cause depression. So you first needed to get them off alcohol and then you needed to get them a mental health referral. And after all those things were done, then you do transitional housing, and if they didn't blow out of that, you'd look for permanent housing. And you can imagine nobody made it through the continuum. And everybody gets to talk their great work taking care of homeless people, and meanwhile everybody's still homeless. And providing all these services and everybody's still homeless. Or someone turned it on their head and my housing guy Marc Trotz was one of the first under what's called the "housing first model" which is forget all that stuff. First, we house people. They're homeless. Do you want someone to stop being homeless? House them. So we house them. We house them right from the start and then we work on these other problems. And as you might imagine, it's a lot easier to deal with somebody's
mental illness when they're not living under the freeway, right. When they're not, you know, in a situation where they're actually, you know, in danger. Our costs are about to maintain somebody in supportive housing in terms of the real estate cost. Most of the units that we lease are about $1200 a month for someone of which we ask people to pay about $300 of their own income on average because we ask people to pay a third and most people in this situation are getting a $900 Social Security check. So our costs are about $900 a month. The rest of the health care cost, we can generally get by billing Medicaid for visits that they get either at our clinics or for sending out nurses. 

The cost of a hospital day is about $3000. So you don't have to save very many hospital days in order to make this work. And what the body of research shows which is which you would all figure out anyway, is that whether it's cost saving, cost neutral, or just cost effective, depends entirely on the population you choose. So if you only provide housing to people who are constantly in the hospital, it's money saving, because a hospital day is so expensive. If you provide housing to homeless people who avoid hospitals, it's a very cost effective thing to do in terms of the quality of life but it's not cost saving because they were avoiding the hospital, right? They were living under the freeway, right. There's no cost saving. And the challenge, and this is--if you will from the examples I gave, this is my modern day challenge. There is a specific part of the federal Medicaid code that says that Medicaid cannot pay for housing. And I'm currently trying to figure out and if any of you want to work with us on smart ideas, I'm trying to figure out how to defeat that. I'm not easily deterred. It is my cynical defeat which is I say, "Oh yes, that's not true. Medicaid does pay for housing, they're called nursing homes." So you're willing to pay for housing federal government as long, you know, I institutionalize somebody, you know, at $250 a day but you won't let me house, but that's not going to get me what I want. The closest I've seen to what I want is that Indiana has been successful at convincing Medicaid to pay them a premium, like you're talking about primary care premiums for paying more for primary care doctors, has agreed to pay a premium under Medicaid for everyday the health plan keeps a homeless person housed. So they're not paying for the housing because the federal law prohibits Medicaid being spent on housing, but they were willing to go the step of paying an incentive to the plan for keeping them housed. So, you know, I'm trying to be on that cost of figuring out, you know. OK. So I can work with that. I can--that's the kind of thing that I like. You know, you just need a way around it because again, you know, if we brought a bill to Congress, you know, could you find a sponsor? Yes. You could I think pretty easily get somebody to sponsor a bill lifting that exemption. Could you get it passed? Absolutely not. No, no way, that in today's era they're going to lift that ban, so you got to find a different way.

>> Just a follow up to that, you know, is DHS planning to maybe apply for a social impact bond or [inaudible], things like that or, you know, Medicaid cannot cover housing?

>> Mitchell Katz: Sure. So social impact t bonds are, you know, a hot fashion at the moment. But my [inaudible] is that a reason they're not more widely used is that it's not easy to find situations where you can guarantee the return of investment. And so just to say it in another way, so health innovation bonds, the idea is like any other bond, they give you the money upfront and you pay it back over time. So, if you have an innovation that you believe or have strong more than believe, you have strong evidence to say, "We'll save you downstream cost," it
makes sense. The problem is that even the housing, depending on who you do again, it's much more cost effective than say doing CT scans on smokers to try to pick up early lung cancer, you know, people have done that analysis, but that's not prohibited by Medicaid and so Medicaid pays for that. But could I do a social impact bond for more housing for the homeless? Yes, but it would have to be restricted to only people who have a lot of days in the hospital. And my goal is to go way beyond that. What I want to do is I don't want to see, you know, a lineup of wheelchairs on skid row. I think that's just unacceptable in a city and country as rich as this, to believe that the best we can do is a series of wheelchairs right down skid row. I mean, there has to be a better way. But to the extent that those people don't go in the hospital, I don't have a savings, so I can't use a social impact bond just because it's something good I want to do. You have to be able to pay the investors back. The place I believe there might be the social impact bond that I'm interested in looking at right now is some of the jail diversions. And the reason the social impact bond might work there is cost of incarceration is $130,000 a year not counting any medical care. So just the custodial part of keeping somebody in jail is 130,000 and there is no federal or state's reimbursement at a local level.

>> [Inaudible] digression, but I hear that number all the time of why is it so high [inaudible]--

>> Mitchell Katz: Deputies. It's a very high density of deputies. It's a 24 hour shift of well-paid people. I'm not saying they shouldn't be well-paid but, you know, there are a lot of them and they're well-paid, right. And, you know, I don't--you know, I mean, given how we've incarcerated people and the violence, I'm not sure I'd be advocating for fewer guards. I don't really know. But that's the expense you're paying for. No, most of the expense is the guards, because I know it does not include medical care. So, if you could create a diversion program, we are diverting people out of jail, almost everything is going to be less expensive than $130,000 a year, right? I mean, that's a job and the home, right, and some support. So--But again, you can see how that's a limited--right, and of course, you know, we don't--you're not going to get political support for diverting anybody with a violent anything, right, nor am I advocating for that but--I mean, I would love to do more diversion for people with mental illness and substance abuse problems, right, with no history of violent crime. I'm just not--you know, I understand why it's illegal to sell drugs and I'm not sure that I disagree. On the other hand, it's hard for me to say exactly what I think the benefit, what is the size, someone gets picked up for selling drugs, we put them in jail for two or three years. What have you accomplished? I mean--

>> We are actually doing exactly that. I work for an [inaudible] and we actually are applying for social impact [inaudible] diversion program--

>> Mitchell Katz: Right.

>> --women's [inaudible] court for non-violent women offenders and substance abuse. But like you said the impact is going to be [inaudible] and social impact bonds right now are limited to $10 million and, yeah, that's probably going to fund if it's [inaudible] every year.

>> Mitchell Katz: Right. Right, well good for you. You're doing what I believe in which is you're making--right, the idea of making a difference is not, you know, making a difference on necessarily the biggest thing in the world, right? It's making a difference. It's making a difference where you can make a difference. And sometimes the problem is very small but it's a real person and good for you for doing that. And maybe on the way you'll either figure out other
strategies that are better or more effective or someone else will use the stuff you do and that's how the world gets to be a better place.

>> I used to travel here a lot and it's pretty simple to say that we're [inaudible] what you're talking about, it seems work pretty well. It help [inaudible] take care of--drugs are not such an issue. Violence is a little bit lower in here. Why is it so hard to get some other solutions which worked over here? I mean, I know you've been talking about it but in a simple way, what would be an answer to that?

>> Mitchell Katz: Well, I think clearly, you're in the world of anthropology as to, you know, why Americans--I mean, and people have written books. There is--Americans are I think characterized by a certain exceptionalism, a belief that America or US is different. And I don't think that the Western Europeans as much believe--I mean, I'm not--I mean, the French, you know, certainly don't see themselves as Italians or Germans, but somehow this sort of rugged individualist kind of thing just doesn't seem as much a part of their national characters as it is that Americans are, you know, very individualistic. They--As a country, we seem to feel that we all get to decide ourselves what we--what we want and without going into, I mean, the measles stuff is all about that of late, right, with people feeling a very hot debate. You know, do parents have the right to simply say that, no, they don't want their children vaccinated and they are not moved by the data that say, well, but measles vaccine doesn't cause autism. It doesn't move them.

^M01:20:15 They are truly not convinced by that. And there are private schools in Los Angeles where--especially like the Waldorf schools, like half the kids are unvaccinated. I mean, it's a perfect setup for an epidemic of measles. And you have this great reluctance for saying, "Well, wait a minute, you don't just get to decide as an individual." We don't--Americans don't like to dictate. OK. Well, thank you so much.

^M01:20:45
[ Applause ]