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THE JOHNS HOPKINS UNIVERSITY

TOPIC: AMERICA'S HEALTH CARE CRISIS

MODERATOR: JERRY ZREMSKI

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MR. ZREMSKI: Good afternoon, and welcome to the National Press
Club. My name is Jerry Zremski, and I'm the president of the National
Press Club and Washington bureau chief for The Buffalo News and. I'd
like to welcome club members and their guests who are here today, as
well as those of you watching on C-SPAN.

We're looking forward to today's speech, and afterwards I'll ask
as many questions as time permits. Please hold your applause during
the speech so we have time for as many questions as possible. For our
broadcast audience, I'd like to explain that if you hear applause, it
may be from the guests and members of the general public who attend
our luncheons and not necessarily the working press. (Laughter.)

I would like now to introduce our head table guests and ask them
to stand briefly when their names are called.

From your right, Peter Schmidt, deputy editor of The Chronicle of
Higher Education and author of a new book on college affirmative
action called "Color and Money"; Albert Teich, director of science
policy at the American Association for the Advancement of Science;
Roland King, vice president for public affairs at the National
Association of Independent Colleges and Universities; Bill McQuillen
of Bloomberg News; Wendy Brody, the wife of the speaker.

Skipping over the podium, Angela Greiling Keane of Bloomberg News and the chair of the National Press Club Speakers Committee. Skipping over our speaker, Ira Allen, freelance health reporter and Speakers Committee member who organized today's event; Kristina Johnson, the provost of Johns Hopkins University and a guest of the speaker; Carole Schweitzer, executive editor with the National Association of College and University Business Officers; and Mary Woolley, president of Research America. (Applause.)

People around the country largely know Johns Hopkins University as home to one of the nation's leading medical hospitals. The Johns Hopkins School of Medicine and School of Nursing and it's Bloomberg School of Public Health -- yes, that Bloomberg -- (laughter) -- have long played a strong and important role in American health care. And our speaker today, Johns Hopkins University President William Brody, has been an outspoken national advocate on behalf of a better, safer, more cost effective health care system for years now.

Of course, here in Washington, many of us know Johns Hopkins through its Nitze School of Graduate International Studies, one of the finest schools of international relations in the country. The school has an international character, and in fact it has two other campuses -- one in Italy and one in China. In June, the campus in China held a party to celebrate its 20th anniversary. It was an elaborate event with 800 guests, and the keynote speaker was Dr. Henry Kissinger. Just before Dr. Kissinger's remarks, our guest today rose to offer a welcoming greeting. But what few in the audience knew was that he had spent the last year learning how to speak Chinese, and so he delivered his remarks in a pretty passable Mandarin. The crowd went wild and as our guest returned to his seat, Dr. Kissinger grabbed his arm, leaned over, and said, "Nixon taught me never to follow the talking dog." (Laughter.)

Dr. Brody, let me assure you, that won't be happening today. (Laughter.)

William Brody has been president of the Johns Hopkins University for 13 years. He trained at both MIT and Stanford, where he received both a medical degree and a Ph.D. in electrical engineering. Dr. Brody helped co-found three medical device companies, and from 1984 to 1987 served as president and chief executive officer of Resonex, the maker of an innovative magnetic resonance imaging machine. He has more than 100 publications and one U.S. patent in the field of medical imaging.

Dr. Brody has also written extensively about the U.S. health care system as a physician and as an engineer, and that is why we invited him to join us here today -- to talk about what is being promised in terms of health care reform in the 2008 presidential campaign, and about what is possible. So please join me in welcoming Dr. William R. Brody, president of Johns Hopkins University, to the National Press Club. (Applause.)

DR. BRODY: You know, coming to speak at the National Press Club is one of those opportunities that really makes you sit up and take notice. So when I was first invited, I asked a friend of mine who is

a member, how big is the audience? He told me the room seats 300, but a couple of years ago they managed to squeeze in 350. So I said, "Great! What's it take to get that kind of turnout? You know, who was the speaker?"

And he said, "Angelina Jolie." (Laughter.)

So you know, I said, "No problem. I mean, she's a pilot; I'm a pilot." (Laughter.) "You know, what's she got that I don't have?" (Laughter.)

He said, "Do you want a list?" (Laughter.)

So I'm very grateful to all of you in the audience for coming today, and I plan to make this an hour well spent in your busy lives. And Jerry, thank you for your very kind introduction and the warm reception I've received from all the members and the staff here at the National Press Club.

It's especially gratifying because part of what I want to do today is to dispel some wishful thinking about what's going on in America about reforming our health care system. This wishful thinking is often read in the press or frequently heard about from our presidential candidates, but I think we're not getting the whole story. So people often ask me to explain the contradictions in our health system, and I use this story by way of analogy.

You know, every time I go to the British Isles, I cringe at the thought of having to drive on the wrong side of the road. So there's been a lot of pushback from tourists. And so I'm happy to announce that the British Tourism Authority has decided that all cars should start driving on the right side of the road in Britain. Now, this is welcome news to many of us. Unfortunately, the London cabbies and the truck drivers -- or lorry drivers, of course, as you would say in the Queen's English -- complained bitterly about the high costs of having to convert their vehicles from left-side drive to right-side drive.

So they came up with the following compromise: Beginning next year, cars will drive on the right side of the road, but lorries and taxis can continue to use the left side of the road. (Laughter.)

Now, the British are calling this the American medicine compromise in honor of the world's only health system where everyone gets to play by their own set of rules. (Laughter.)

Can you imagine? You know, what a nightmare. Yet here in America, it's exactly what we experience when we get sick. I was talking to somebody who was in the hospital recently and -- you know, it's like we have hospitals and doctors driving down one side of the road and insurance companies and pharmaceutical companies or device companies driving in the same lanes but going in the opposite direction. It's a high-speed game of chicken and no one's directing traffic, and you as the patient have to figure out how to cross the road safely.

So I'm pleased to come here today to talk about America's health care crisis, and to do this, I'm going to talk about the five C's of

health care. These are the basic issues in our health care system that illustrate how we are driving two different ways down the same side of the road.

Now, two of these C's you already know about: cost and coverage, and these are the issues that everybody's talking about. The presidential candidates bring this up virtually every time they talk about health care -- the rising costs of health care and the falling rates of insurance coverage. But if you're only talking about cost and coverage issues, you're missing a big part of the health care story, and that's the other three C's that I'm going to tell you about today because in my view, these are key to understanding what we need to do in order to get cost and coverage solutions to the health care crisis.

Right now nobody wants to hear that. Health care is emotionally charged. Every one of us cares deeply about the kind of medical treatment we and our loved ones get, and when somebody's sick or injured, we -- that person is uniquely vulnerable, and we all understand that.

Yet all too often we see stories indicating that our medical system, a system that in some respects is considered the finest in the world, still makes mistakes, leaves people out, and fails to provide the best possible care for all.

America's health care is the world's most expensive by far, which is measured both in the costs per person as well as the percentage of our gross domestic product. And yet when the World Health Organization ranked all national health systems by performance, guess what? The U.S. placed 37th right behind countries such as Morocco, Cyprus and Costa Rica.

So do we spend so much on health care, and why aren't we getting our money's worth? We all want to know the answer to that question.

And while everybody is talking about costs of health care and the lack of coverage, meaningful change will only come when we address the other issues.

So these are the other three C's, issues we're not hearing about. And I call them consistency, complexity and chronic illness.

We can't provide health care for all unless we control the spiraling costs of health care, for sure. But we won't control costs until we deal with these other issues. These are the questions we should be asking the presidential candidates about their health care platforms.

And that's why as the president of Johns Hopkins University I've joined with the National Coalition on Health Care and the Retirement Living TV Network to invite the major presidential candidates and other leading health care experts to talk about how we can solve our health care crisis.

We've asked them to sit individually with me and a national news anchor for meaningful in depth conversations focused only on health

care to be televised during the campaign.

These programs should give each individual an opportunity to explain in detail what he or she proposes to do about this issue.

Now polls show that health care is the number one domestic concern. Americans expect action. But of course the subject is vast and complex. Health care expenditures now exceed \$2.2 trillion a year and continue to climb relentlessly. And it's enormously difficult to understand or even to accurately describe our health care system.

In fact the biggest problem is that there really is no health care system. You can talk about the British medical service, you can talk about the German medical system or the Canadian national health plan. But when it comes to describing the American health care, when it comes to describing American health care, there is no system that you are talking about. Medicare is different from Medicaid is different from private insurance, it's different from no insurance.

Individuals in these different situations have different medical experiences, and unfortunately, often, different health outcomes.

Simply stated, the U.S. does not have a health care system. Instead it could be best described as a patchwork quilt of different responses to different problems. And as the years have gone by, unfortunately this quilt is fraying and has developed some rather gaping holes.

So to mend things we have to address these other three C's of consistency, complexity and chronic illness. In the next few minutes I want to describe how these issues will determine how we provide and pay for health care in America in the coming years.

So first and perhaps most importantly, we have to tackle the problem of consistency. Now one of our presidential candidates says, I'm sure America must have the best health care system in the world. After all, all the time I get calls from people in Europe wanting a referral to a hospital in the United States. And in one sense this is true. Every year thousands of wealthy patients travel from all parts of the globe to access world class health care, world class treatment for heart disease, cancer, neurologic diseases, joint replacements, and so forth.

And yet here's the dirty little secret. While the best of the best of U.S. health care is the world's finest, on average, our health care system performs poorly. The RAND Corporation looked at 30 common medical conditions in about a dozen American communities. They found that patients get the appropriate treatment only about 55 percent of the time. In other words, roughly half the time when patients go to the doctor they didn't receive the care that they should. And this was for conditions which were garden variety conditions in which doctors universally agreed upon what the appropriate diagnosis and treatment was.

So the number one challenge I think we face in our health care system is variability. For instance anyone who has had a heart attack and is being discharged from the hospital should be prescribed

aspirin, a beta blocking drug to lower the workload of the heart, and if you have high cholesterol, a lipid lowering drug. This is the holy trinity of prevention of further heart attacks confirmed by NIH research. All doctors uniformly know this.

Yet the RAND Corporation found that only six out of 10 patients who were discharged from the hospital after a heart attack were going home with these prescriptions in hand. And those numbers varied tremendously by hospital. Some got close to 100 percent; others far less than half.

Consistency, which is often just another measurement of quality, is the great challenge we must overcome.

So while the best of U.S. health care is the best in the world, not everyone is getting that care. So the bad news is, if we all got sick in this -- the room tomorrow, you on the left half would get the appropriate care, and you all on the right half would not get the appropriate care. It's a disgraceful situation, and it's not a matter of whether you have insurance coverage. It's all about consistency of care.

Now in other countries with organized health systems physicians practice according to established guidelines. Not so in the U.S. where practice standards are mostly nonexistent. Now did you know that it's three times as expensive to take care of a Medicare patient in McAllen, Texas as it is to take care of one in Lynchburg, Virginia? Dr. John Wennberg at Dartmouth Medical School studied 1996 Medicare data, and he found that after you adjust for cost of living and all the risk factors that we know about, it costs about \$3,000 a year to take care of a Medicare beneficiary in Lynchburg, Virginia, or slightly over \$9,000, almost three times, \$9,000 a year to take care of one in McAllen, Texas. And yet there was no demonstrable improvement in health outcomes for the patients that were more expensively treated in Texas than the ones in Lynchburg, Virginia.

So we need to ask the candidates how can we consistently deliver the best possible care.

Now number two, the number second C, is complexity. It used to be if you were hospitalized you needed a doctor. Nowadays you need a doctor, possibly a lawyer, but certainly an accountant to help figure out your health bill. High administrative costs for providers and payers is just the beginning of a hopelessly fragmented, uncoordinated care delivery system.

And the sad truth is, in two areas of health care America is the undisputed leader: first, as we mentioned previously, our high health care costs; but secondly, in the complexity of how we deliver care. It should surprise no one that these two situations are closely related.

Has anyone here in the audience been to the hospital for a procedure and not been confused and confounded by the billing process that followed even if you had insurance? If you're out there, we'd love to have you bronzed and put you in the Smithsonian.

Hospitals are asked all the time, I'm asked all the time, Bill, do you go out of your way to hire complete idiots to staff your billing office? (Laughter)

And I'd like to say, no, we don't even go out of our way. But the fact -- (laughter) -- the fact is, it's just the opposite. We hire really bright talented people, and then we spend a lot of time training them.

But the outcomes are abysmal because every insurance plan has different rules, different eligibilities, different ways of coding the diseases, and different things that they will reimburse or not reimburse from. Health care billing is the modern-day Tower of Babel in which no one speaks the same language.

Even Medicare, which is the nation's most efficient payment system, is difficult to understand. One time I was at a meeting with John Breaux, who at that time was Senator from Louisiana and a leading expert on Medicare, you know, he observed that the Medicare regulations are three times the size of the IRS Tax Code -- this is the Tax Simplification Act times three. (Laughter.) And Senator Breaux told me, and I'll never forget this, he said, "I have to decide whether Medicare should reimburse for colonoscopy or barium enema in order to screen for colon cancer." And he turned to me and he said, "Dr. Brody," he says, "I've had both, and I don't like either one of them." (Laughter.)

Well, it used to be at the Johns Hopkins Hospital we had to deal only with a small number of organizations that paid for medical care. There was Medicare, Medicaid, Blue Cross-Blue Shield, and a handful of private insurers. Life was good. Yesterday I called Rich Grossi, who is the chief financial officer for Johns Hopkins Medicine, and I asked him how many payers that we deal with today. He did some digging, and the numbers shocked even me. He said at the Johns Hopkins Hospital we have to bill more than 700 -- get this, 700 different payers and insurers. These are HMOs, PPOs, MCOs, IPAs and a literal alphabet soup of other organizations -- each one with their own set of rules regarding what services are covered, the level of reimbursement, and what kind of documentation and pre-approval is required. It's simply an administrative nightmare.

Nationally, this kind of inefficiency costs patients billions of dollars. Billing collection and payment administration represents, by any conservative estimates, 20 percent of health care costs. If there were a common format that all payers and providers were required to use, much of the administrative burden could be removed. And you, as patients, might be actually able to understand your medical bills. So we need to ask the candidates how can we eliminate unnecessary complexity from the health care system.

And the last "C" is chronic illness. Did you know that two-thirds of all Medicare spending is for beneficiaries who have five or more chronic diseases? Eighty percent of all health care costs -- 80 percent of all health care costs -- involve patients with one or more chronic illness. Illnesses like hypertension, diabetes, chronic obstructive pulmonary disease, arthritis, asthma, or depression. It's a relatively short list but these consume a tremendous amount of the

health care dollar.

Part of the miracle of modern medicine has been our ability to turn killer diseases into manageable life-long chronic conditions. American medical research, funded by the federal government through the National Institutes of Health, has really revolutionized our ability to treat the sick. Our nation has been very well served by that investment. Diabetes is an example of this, HIV infection is another; as is the significant decline in deaths from heart attacks over the past few decades.

Formerly, diabetes, HIV and heart attacks were death sentences. Now they're typically-managed conditions that may require daily medication and regular medical attention. But chronic conditions are both difficult and expensive to manage, so if we begin to focus on disease management there are big gains to be made, both for better patient care as well as for reducing costs.

Now two strategies could have a profound impact on lowering the morbidity and mortality of these conditions, not to mention drastically reducing the dollars spent treating them. The first is developing more effective means to prevent or delay the onset of these diseases, called preventive care; the second is promoting more coordinated cost-effective therapies to treat them -- and we need to be doing both of these.

As an example, right now we are creating a nation-wide epidemic of obesity which, in turn, is generating a nation-wide epidemic of diabetes. The last place, the worst place, the most expensive place to be treating this is in a hospital operating room, 20 years from now, performing amputations. Yet our whole health care system remains oriented towards the care and treatment of acute illness. We can't provide nutritional counseling to prevent obesity but we're well-equipped to perform amputations on diabetics. There's a huge, huge disconnect.

Now a recent poll found that more than three-quarters of both patients and physicians believe that fundamental reform of the health care system is needed to provide better care of people with chronic conditions. Medicare beneficiaries with five or more chronic conditions see an average of 13 different doctors and fill 50 prescriptions a year. For these patients, their illnesses become a full-time occupation. So we need to ask, how can we better manage, and how can we better care for chronic conditions.

So consistency, complexity and chronic illness -- these are the three writers of our health care apocalypse. These are the three challenges we must confront. The presidential candidates have been talking a lot about costs and insurance coverage but until we confront consistency, complexity and chronic illness, no effective cure for our ailing health care system is feasible.

Today it's been my honor to suggest to members of the Press, three critical questions we should ask every candidate about health care. Now it's your turn to ask the questions that you'd like to ask of me. Thank you so much.

(Applause.)

MR. ZREMSKI: Okay, we have a lot of questions on health care and some on academia generally. First of all, you didn't specifically address the legions of uninsured people. Do you have a position on universal coverage for all Americans ,or just for the poor?

MR. BRODY: Well, I think there's, generally, universal agreement that we need a way to universally cover everybody. We've got to get everybody in the health care system. Letting people come into the emergency room for their first encounter with the health care system is neither cost-effective for the system, nor is it good medical care.

I think the issue is, how do we do it? And I think there are a number of potential solutions, but within that is this issue, is, what is the benefit? In other words, what are we going to cover and not cover? And there, in some sense, we have the sixth "C," which is the consumer, because consumers of health care expect that everything ought to be covered and we can't afford to cover everything.

So one of the questions of universal coverage is -- is now playing out in California, is what should be the benefit which we entitle everybody to obtain -- either through purchasing insurance or through tax incentives?

MR. ZREMSKI: President Bush recently made a comment along the lines of, oh, Americans have access to health care, they can always go to the emergency room. What did you think of that comment?
(Laughter.)

MR. BRODY: Well, if you came to the Johns Hopkins Hospital you would see, really, the world-class health care -- and people coming from all over the world to access it. But within the shadow of the Johns Hopkins Hospital -- literally within a half a block, you would find a mother who has to decide, a single mother decide whether she uses the money that she has to purchase food to put on the table for the family to eat that week, or to buy the medicine for her asthmatic child.

And if she doesn't buy the medicine for that asthmatic child, that child will end up in the emergency room and possibly die, because it's been shown that if you don't do the preventive or the maintenance therapy for asthmatics, they're at much higher risk for catastrophic complications. So I think we do have to change the dynamic. We can't have people coming directly to the emergency room.

MR. ZREMSKI: Okay, if it were December, 2008, and you were advising the next president, what two things should he or she do first to assure better health care coverage?

MR. BRODY: I think I will leave that to the politicians. I think that really, the question about where we go is a question of the political will. Clearly, the people of America have decided that this is an important issue. I think I would raise the issue to the politicians. You know, if you or I go to the doctor, the first question we ask the doctor is not: Are you a Democrat or Republican? The question we ask is: Am I going to get the appropriate treatment

and can I afford that treatment? And I think for a country which spends twice as much per capita on health care as any other country in the world, we ought to be able to figure out a way to provide that kind of care. And that is a policy issue. I'm not an expert on policy.

MR. ZREMSKI: Have you heard back from presidential candidates and have any said they will come in and talk and which ones if they have said?

MR. BRODY: We don't have the schedule. We're currently in discussion with a number of the political campaign teams and working on trying to find the appropriate time. We're also planning to have one session with health care experts in sort of a town hall-type meeting as well.

MR. ZREMSKI: Dr. Ronald Selman (sp), editor emeritus of the New England Journal of Medicine, has often said that if the money currently spent on health care in the U.S. were spent honestly, efficiently and intelligently, it would be able to cover every man, woman and child here in the country with the finest health care in the world. And he has also said that a universal, you know, single-payer plan is inevitable. Could you comment on those thoughts?

MR. BRODY: Well, I wouldn't necessarily agree with the latter. I do think that insurance as the current concept is not working, and is going to have to be more so that we find a way to cover everybody. Whether that's done through a single government-driven system or that's done through a private insurance system I think is a different question.

I think if you talk to any physician or nurse, any health care provider, they will tell you that there is so much wasted money in the system that if we can figure out how to redeploy it effectively that we can afford to do much more than we currently do. And again, I think the statistics would bear that out. The question is: How do we do it and do we have the political will to make those changes?

MR. ZREMSKI: How can insurers be prevented from sabotaging health care reforms through a misinformation campaign like they did in 1993? (Laughter.)

MR. BRODY: Well, look, I'm not going to pick on any one group, but I think when it comes to the issues of coverage -- I go back to Senator Breaux -- you've got everybody lobbying Medicare and it may be physicians, it may be patients, it may be the particular disease group that wants coverage, it may be a pharmaceutical company. Everybody is at a table arguing that their position needs to be heard. And so what we have done is really put together a patchwork quilt of solutions based on -- not on a rational allocation of resources, but on trying to keep the squeaking wheels greased in some way.

MR. ZREMSKI: Now, probably a question from the insurers. If all payers adapted the same coding and billing practices, wouldn't that take away from their competitive drive and upset their stakeholders?

MR. BRODY: That's a question -- I think you should have somebody

from an insurance company speaking and ask them that question. I think clearly we could do a lot to have much more uniformed standards for billing, without restricting the creativity, if you will, and the flexibility of insurers to provide unique products for their constituents.

MR. ZREMSKI: Regarding the need for consistency, what do you think should be done and whose responsibility is it -- if not the federal government, who else? If yes to the federal government, which existing agency?

MR. BRODY: Well, I think you see a number of movements. If you go back to aviation, which I think is good -- aviation safety was in trouble in the '60s when there were some major airline crashes. And the aviation industry began a series of changes which led to what I would call practice guidelines and standards, which ultimately were adopted by the federal government through the FAA. But it was really an industry-driven shift. And I think what you're seeing in health care is the beginnings of that.

The Commonwealth Fund -- Karen Davis, the president, is here today -- has sponsored a consortium to look at high-performing health care systems, as well as health care reporting cards. The New York Hospital -- New York City Health and Hospitals Commission has just decided they're going to publish all their health statistics online. So you're beginning to see more transparency. And as you promote transparency and quality measures, you begin to drive performance more consistently.

MR. ZREMSKI: One questioner says: Regulators and insurers have taken over the practice of medicine. How can physicians regain control of medicine?

MR. BRODY: Well, I think that as a physician, we have been notoriously resistant to the idea that we need guidelines and standards. And I think that the medical profession has slowly begun to recognize that it needs to develop those standards and practice guidelines and promote them, less somebody else comes in and does it for them. And I think that's really important. Practicing to certain performance standards and measuring yourself against that is one way both to improve performance as well as to drive towards a more consistent health care delivery for all.

MR. ZREMSKI: Many doctors complain about the rising cost of malpractice insurance and say that their liability should be reined in. Do you see the legal side of health care as part of the cost problem?

MR. BRODY: Well, I think there are a number of studies that have shown that -- for example, Harvard did a study that 80 percent of health care suits, of malpractice suits -- not necessarily awards -- were for situations in which there was no demonstrable error by the physician. Conversely, Health and Human Services did a study and showed that only 10 percent of the time do patients who have legitimately been harmed by the system get any compensation for their harm. So I think it's a system right now which is unfair for the patients, as well as unfair for the physicians. And we need a system

of legal justice, not necessarily one that's fought out in juries in small towns.

And I think the question that nobody knows is how much is the practice of medicine impacted by the cost of defensive medicine -- ordering tests and doing things. But clearly we do need to look at reform and develop a system which is fairer for patients particularly, who unless you have a particular kind of injury, it's very hard to get any compensation through the system.

MR. ZREMSKI: Congress and the president are engaged in a difficult debate about the future of the State Children's Healthcare Insurance Program. Should that program be expanded and can it serve as a template for broader health care coverage?

MR. BRODY: Well, I won't comment on specific legislation. I think that the idea -- this is presumably the CHIPs program that you're talking about. Clearly, we see at Johns Hopkins hospital a lot of children who don't receive the appropriate medical care, who come from families that lack the resources. So I think it is something that is a good investment that our country should make. How you make the investment, obviously, is devolved more to the states than to the federal government, which I think is not a bad way to go. But again, it boils down to this whole issue is we're spending a lot on health care. We just need to figure out how to deploy the resources -- not necessarily to spend more than we're spending, but to redeploy them in a more effective fashion.

MR. ZREMSKI: What do you think about Medicare for all?

MR. BRODY: Well, in a year and a half I'll think it's probably a great idea! (Laughter.) In the interim, you know, I think half of the political candidates say Medicare should go away and the other half are saying that Medicare should be the model for everybody.

The fact is that irrespective of which party, the federal government is going to continue to be a large payer for healthcare, and I believe that private insurance and private delivery systems are also going to continue to be there. And so what we have to do is not focus, again, on whether this is a Republican or a Democratic issue, but how do we make all of the systems better, and I think that's the real question.

MR. ZREMSKI: A recent report in the NEJM posits that the generation being born and raised now will not outlive, in terms of longevity, their parents. What can be done to reverse this alarming trend?

MR. BRODY: Well, I'm not familiar with the article in The New England Journal of Medicine. I think if you look at things like obesity you have to be concerned that a population that's becoming morbidly obese in the percentage that it is is not going to have the same longevity in the past. But I think it goes back to public health and education and what goes on in the schools -- back to this concept of paying people to talk about nutrition instead of necessarily paying them to amputate legs from diabetics 40 years later.

MR. ZREMSKI: When you talk about prevention how do you -- who really leads that effort? Is that a federal government effort? Is that a healthcare industry effort? How do we get the message across that prevention, better diet, no smoking -- all of that stuff -- really is saying that it ensures your health as you grow older?

MR. BRODY: Well, I -- as an employer -- Johns Hopkins as a large nongovernment employer in the state of Maryland I think it's incumbent on us as an employer to begin this effort irrespective of whether the federal government or the state government play a role. I think all of them should play a role in public health and public health education, and employers as well. We have a vested interest, clearly, in making sure that our employers are fit and -- that our employees are fit and healthy, and I think there's much more that we can do. And as our healthcare costs rise we're beginning to think more strategically again about how we deploy our healthcare insurance dollars for patients in order to provide that kind of benefit. Smoking cessation, substance abuse, and weight control -- weight loss -- are three areas that could have a major impact on the healthcare dollars.

MR. ZREMSKI: What are your thoughts on improving care for the dying?

MR. BRODY: Well, I think, you know, there's -- there are various statistics that a large percentage of the healthcare costs are spent in the last year of life. Again, Medicare has very good statistics on this, and a recent study by Dr. Wenburg who I quoted earlier looked at care -- costs of care in the last six months of life and he looked at the best hospitals according to U.S. News and World Report. By the way, when Michael Bloomberg was chair of the Hopkins board before he ran for mayor I kept trying to get Michael Bloomberg to buy U.S. News and World Report. (Laughter.) I figured that was a way to guarantee that Hopkins was higher in the rankings.

But nonetheless, the -- what they found, for example, was that Johns Hopkins Hospital compares very favorably in terms of low costs for taking care of the elderly with chronic conditions in the last six months of life compared to other hospitals on the east coast. But we weren't -- didn't compare favorably with hospitals on the west coast. So what I've done is taken that data and challenged our people, go out to California and find out what they're doing to reduce costs. Again, driving -- producing data and creating transparency in performance is the best way to drive the cost and -- drive the quality up and the cost down.

MR. ZREMSKI: You mentioned U.S. News and World Report. As a scientist, what do you think about the validity of their hospital rankings?

MR. BRODY: (Laughter.) Well, the years that we're number one I think they're great. The years that we're not number one I don't think they're so good so it goes back to my earlier comment about buying U.S. News and World Report. (Laughter.) You know, I would say that given the large variability in the healthcare system, I believe that it's incumbent upon patients to ask questions. Sometimes you can't get the answers, and I think I'm a great believer that we should

be promoting transparency. Hospitals should be reporting mortality statistics. New York State does now post the results by surgeon and by hospital for open-heart surgery. If you have open-heart surgery the most important questions you want to ask the surgeon, how many cases you do, what's the morbidity, mortality, and so forth. And you oftentimes can't get those questions and if you have to ask the physician, you know, the patients are -- feel embarrassed to have to ask the physician that question.

But in New York you can get it and once those data are published guess what? People who aren't doing so well -- the surgeons either quit doing the surgery or they get better. So it's an important way to do it. Now, the problem is we can't do that for all diseases. It's not as easy to determine the success rate in treating rheumatoid arthritis as opposed to coronary bypass surgery, but there are certainly conditions for which publishing data and results statistically are useful and informative.

MR. ZREMSKI: What are the advantages and potential problems in terms of cost, care, and privacy of moving from paper to computerized medical records, and what's the Hopkins approach?

MR. BRODY: Yeah. Well, the major large hospitals are making a push towards electronic patient record as is Johns Hopkins because we do have the resources to do this. I think the issue with electronic patient record is that many physicians practice in groups of three or fewer and they don't have the resources. They may be located in rural communities where they don't even have broadband access through their phone DSL connection or cable connection.

So I think it -- we are moving to computerized medical record. It is important. It isn't going to solve all our healthcare problems overnight. I say, you know, we'll have a paperless hospital after you have a paperless office. Does anybody here have a paperless office? So it won't solve the problems but clearly providing records so that when patients are treated in one place and go somewhere else we can transfer the data is going to be important, and it may ultimately be the patient that is the repository of actually through a subscription on an Internet site to take care of their own patient records.

MR. ZREMSKI: When a patient is discharged from a hospital there's often a gap between their discharge and their subsequent care by their primary physician. There is little or if any sort of hand-off communications in this period of time. This is -- (inaudible) -- including patient confusion about who to call, what they should worry about, and what they need to know. How do you solve this problem?

MR. BRODY: Well, we have an active program in patient safety and I think the one thing that -- the most common contributor to problems with patient safety, whether it's appropriate treatment or whether it's accidents, is communication. Communication plays a role probably 90 percent of the time and so we strive and we're far from perfect, but strive to come up with ways of improving communication.

In fact, we brought people in from the aviation industry who teach communication skills -- it's called crew resource management -- to be able to do that so that doctors and nurses, for example, in the

operating room are trained to introduce one another on a first name basis. So when something goes wrong the nurse feels empowered to tell the physician -- the surgeon -- that there's a problem and make it a more -- (inaudible). So we are working on this but medicine has a long way to go.

MR. ZREMSKI: What do you think of the pharmaceutical industry's growing practice of advertising directly to consumers?

MR. BRODY: Well, we are as far as I know the only developed country -- probably the only country in the world -- that allows direct to consumer advertising, and it's not just restricted to the pharmaceutical companies or the device companies. Physicians and hospitals also advertise. And as I watch these ads I cringe because there's not always truth in advertising, and we know that when a patient comes and asks for a drug by name over half the time they're likely to get prescribed that because it doesn't necessarily cost the physician any more to prescribe that particular drug. I don't think it's a positive move. I've always spoken out against it and I continue to do it but it's not just restricted to the pharmaceutical industry.

On the other hand, publishing useful informative data -- and some of those as you talk about are in the form of teaching people about hypertension and the need to get treatment do have a positive benefit. So it's not all negative but I think in general there's a -- the trend is not good.

MR. ZREMSKI: You mentioned the advances we now take for granted, thanks to NIH research. Is this pattern going to slow down or stop with cuts in the NIH budget as we've seen for several years now?

MR. BRODY: Well, you know, there was a sense that, well, NIH budget increased rapidly, it's now time to put that money somewhere else. But I think what we're seeing is that as the NIH budget has actually decreased in real dollar terms over the last three to five years, young investigators -- people who have been trained and brought up in the system -- can't get funded and are now going to be leaving in droves. It's not a good way to reap the benefit of this investment that the NIH and the federal government have made.

So I think we can't allow the budgets to kind of go up and fluctuate in willy-nilly. Really there needs to be a commitment insistent fund and at least keep it at inflation or better so that we don't lose people at a time when we're on the verge of so many breakthroughs in understanding and treatment of diseases which I believe are going to help us reduce the cost of -- particularly of these chronic illnesses.

MR. ZREMSKI: Another questioner also mentioned the issue that you just raised of bright young people, medical researchers getting discouraged and leaving the business. How big and bad a problem is that right now and is consistent NIH funding the only way to solve it or are other things going to have to be done as well?

MR. BRODY: I think federal research budget in general and NIH in particular is critical. It used to be when we hired an assistant

professor we figured it would take them three years to get an NIH grant. And we would have to support them financially and their research financially until they got that grant. Now it's at least five years. I'm told that the average age that a person gets their first NIH grant -- and I'm not sure, Mary Willy (sp) may know -- is 42.

MS. : I think it's 44.

MR. BRODY: Forty-four.

So we're taking people -- you know, I went to a talk at a different meeting and this young guy got up who'd started a company and he's in front of a bunch of gray-haired men and women, executives, from the computer industry and he gets up and he puts -- his first slide is, "Eighty percent of Nobel laureates made their discoveries while they were within six years of graduating from school."

And he looks at all these old people and says, "You guys" -- and this guy started a company, he dropped out of college to start a company -- very successful. And the world of creativity belongs to the young people. So we've got to be able to have very young people be able to get NIH grants and do creative research.

And as we drive up the average age of your first grant, we drive creativity out of the system. I think it's really important. And that is the role of NIH and NSF and the federal research budget. Nothing else really takes the place of that.

MR. ZREMSKI: CMS has recently declared that it will not reimburse for avoidable complications, yet not all complications are avoidable. The writer says, "For example, the actor Christopher Reeves died from complications of bed sores despite exemplary care." Is this not yet just another covert financial ploy to simply force providers, not payers, to ration care?

MR. BRODY: Well, I think you have to put the latest CMS guidelines into greater context. For years, we have reimbursed for complications as -- in other words, the complexity of care. If somebody gets an infection, we've treated that as an unavoidable complication and paid more for it. And I think now there's a recognition that some complications can be avoidable or reduced and we need to have financial incentives that go the other way that actually incentivize you to try to reduce complications.

The trick is to find the right incentives. Incentives always work -- they just may not work the way you think they are. And if the incentives are poorly designed, everybody's frustrated.

There's -- this is part of a national trend to pay for quality in one form or another. And I think it's generally a good idea but it needs a lot of work to be sure that we are rewarding the kind of behavior that we want.

MR. ZREMSKI: Would the release of Medicare claims data to the general public be timely and constructive or would limited flawed data be widely misinterpreted by an unsophisticated audience without any

background in health care?

MR. BRODY: The answer's yes. (Laughter.) Both -- the answer's both. I think they're probably talking about the morbidity-mortality data for Medicare. I think in general hospitals and providers should be in the position of releasing data on their performance. And let's let the public make a decision.

Again, if you look at what New York Health and Hospital (ph) is doing -- corporation -- they're releasing data, morbidity-mortality, infection rates, surgical site infections, treatment of heart attacks. And then the public can look at that. And then we can -- and we can have people who can help interpret it. But unless you shine light on it there's no way to drive performance to say, "You know, our mortality rates are too high. We really need to get them down." Or, "Our infection rate is too high, let's get it down." If you don't publish it and shine light on it, it's very hard to get action to correct it.

MR. ZREMSKI: American higher education, of which Johns Hopkins is such a key player, seems to function pretty well without being a highly coordinated system. Why is that different than health care? (Laughter.)

MR. BRODY: I think that there's a couple of differences. One, we agree in education, even though it's not highly coordinated, we agree on what the minimum benefit is. In other words, we agree that people who go to college should spend about four years and should learn sort of a set of things in college.

If we could do the same thing for health care, we would go a long way. You know, if we say, "Well, we're not going to cover, you know, treatments for erectile dysfunction but we are going to -- and acupuncture but we are going to cover this" -- I mean, I don't know. It's much more complicated. You know, we all know that you ought to have some algebra and calculus and you ought to have a language and, you know, there're a set of things that we pretty much agree upon. But we don't know what -- we can't agree on what those things are for health care.

MR. ZREMSKI: You talked a while ago about the young medical researches and how they could be getting discouraged. Let's talk about that more broadly. Is there any concern that you have about U.S. leadership in science being at risk?

MR. BRODY: Well, I think if you don't wake up every morning and worry about that, then, you know, as Andy Grove said, "Only the paranoid survive." We should always -- we are in global worldwide competition. There was a thing on YouTube that some of you may have seen -- said, you know, "If you're one in a million, in China, there are 1,160 of you" -- (laughter) -- you know, and so between China and India, there're a huge number of very bright people who are getting access to education. So we are in a global talent search. And so, yes, we need to be concerned about it.

On the other hand, when I look that the freshmen coming in to Johns Hopkins, I say, "Oh, my, are these kids smart. I'm glad I went

to college when I did because I would never get in today." So, I mean, the kids are terrific. But we do need to be sure that they have the opportunity and the encouragement to major in science and math as well as English and history and international relations and that if they go on to a scientific career we make them have the opportunity to be creative -- in other words to get access to funded basic research.

MR. ZREMSKI: Johns Hopkins has established part-time programs for professional and creative degrees. Some of us in the audience went through these programs. How do you prevent them from becoming second- or third-class given the university's research heritage and the elite status of your full-time students?

MR. BRODY: Well, I think most of the part-time courses, not all, fall under the category of professional education for which is generally is content delivery as opposed to an undergraduate education where the content is secondary.

What we're trying to teach undergraduates is to learn how to learn and then to learn how to think because knowledge has a short half-life and students -- we need to prepare students for careers that haven't been invented yet. So I think undergraduate education is a very different kind of exercise and requires I think it's best done in a community of scholars which is why Internet-based education so far has not taken off for undergraduate education.

When it comes to graduate education, we provide a masters degree in public health over the Internet which you can get from Beijing, China or from Baltimore. So I think it's a very different content, a very different objective.

MR. ZREMSKI: We're almost out of time, but before we ask the last question, we've just got a couple of other important matters to take care of.

First of all, if I could just remind our audience of our future speakers. On September 19th, Ken Burns, the documentary filmmaker will be here; on September 21st, Cristian Samper, acting secretary of the Smithsonian; on October 3rd, Adrian Fenty, the mayor of Washington, D.C.

Next, we have a lot of traditions at the National Press Club, including the presentation of a plaque to all of our speakers.

MR. BRODY: Thank you.

MR. ZREMSKI: And for the healthy beverage of your choice. (Laughter.)

MR. BRODY: Thank you.

MR. ZREMSKI: Okay. And our last question which is not about health care or science or education. You're close to Mayor Michael Bloomberg -- any chance that he'll run for president? (Laughter.)

MR. BRODY: Well, I mentioned every day I get up in the morning

and pray for U.S. science to be leaders, I also pray that Michael Bloomberg will become president. He's fabulous. But I have no idea whether he will run or whether he has a chance. But he's a terrific individual and he's been extraordinarily supportive and generous both to higher education and medicine and public health -- not only to Johns Hopkins but many institutions.

MR. ZREMSKI: Great. Thank you very much. (Applause.) Thank you very much, Dr. Brody. And I'd like to thank all of you for coming today.

I've just got a few last words to say. First of all, tomorrow, September 8th the National Press Club will be hosting its 10th annual 5K run, walk and auction. And if you're still up for running and if you haven't registered, it'd be great if you do. And you can do that by going to www.press.org. The 5K run, walk and auction benefits our minority scholarship programs that send two students every year to universities that they may not otherwise be able to attend. So please try to support us with that if you can.

I'd also just like to thank the National Press Club staff members who played a big part in making this luncheon happen today: Melinda Cooke, Pat Nelson, Jo Anne Booz and Howard Rothman. Also thanks to the NPC library for its research.

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Thank you very much. We're adjourned. (Applause.)

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