MWSP Ep 007 – Dr. Howard Fullman

Announcer: From Curtco Media.

Bill Curtis: Whether you're a health curious, sophisticated individual or you're within the medical or health communities, today's show will air topics that go to the heart of the health care environment. So pull up a chair, pour yourself a veggie smoothie or a good single malt, welcome to Medicine. We're still Practicing. I'm Bill Curtis. We're joined today, of course, with our host of Medicine. We're still Practicing the triple board certified doctor of internal medicine, pulmonary disease and Critical Care, my very good friend, Dr. Steven Taback. How you doing Steve?

Dr. Steven Taback: Hey, Bill, it's good to be here. Nice to see you.

Bill Curtis: Nice to have you here. We have a highly experienced guest with us today. We'll get into his early days in a minute. But during his last few decades, Dr. Howard J. Fullman, board certified in internal medicine and gastroenterology, has held positions of medical director and chief of staff, partner and board member at Kaiser Permanente. And by the way, he's supervised about 4300 staff and about 500 doctors. Doctor. How are you doing?

Dr. Howard J. Fullman: I'm well, Bill, nice to see you.

Bill Curtis: Nice to have you join us. Apparently, when Howard was twelve in New York, he watched as his grandmother was treated for cancer. And he knew then that he wanted to become a doctor. Dr. Fullman earned his medical degree at Northwestern and he completed his gastroenterology fellowship at none other than UCLA. By the way, their football team is the Bruins. But then he became clinical professor of medicine at USC. Their team is the Trojans. He also served as an associate clinical professor of medicine at UCLA Bruins. So before we get down to business, let's start with this. The Victory Bell football series. Howard, who's your team? Bruins or Trojans.

Dr. Howard J. Fullman: Well, Bill, you know, we're such a divided and polarized country. And I think we need to start bringing people together right here in Los Angeles

by making sure that we can be equally proud of both the Bruins and the Trojans. But I do have to say, I'm personally still a Trojan fan because my two boys matriculated there.

Dr. Steven Taback: Ah, I'm a Trojan fan as well because I trained at USC. So welcome to the show. And we're proud to have you.

Dr. Howard J. Fullman: Thank you, Steve. Two great teams with two great traditions. And we're lucky to have such fantastic sports here in Los Angeles,.

Bill Curtis: Including being a football fan. You're also senior operating advisor at Atlantic Street Capital now, focused on medical investments, right?

Dr. Howard J. Fullman: Yes, that's true.

Bill Curtis: We'll talk about that in a little bit. But you were chair of the quality committee at Kaiser. That leads us to our hot topic today. So, Steve, let me ask you first, how are we supposed to juggle the cost of medicine, insurance company limitations and hospital economics, if we're going to try to enhance patient outcomes?

Dr. Steven Taback: That is the big dilemma, is that we have tremendous standards in terms of health care and our expectations that we are going to provide the best and the greatest and the newest health care available to our patients. And yet we have this notion that this is going to come from vaporware, that somehow it will be provided to us. And yet we are really at a crossroads, are realizing that our Medicare system is straining relative to the dollars that are available. Research and development is taking place in the private sector. But then the rest of the consumers are feeling the pain because they're having to pay extreme costs as far as their medications are concerned. And the entire system sort of feels as if it's about ready to collapse, how can we maintain high quality, cutting edge medicine and still manage the economics. And those two things are so diametrically opposed and so much of our gross national product is already being spent relative to health care. And yet we're drowning. Medicare is rationing. Insurance companies are rationing. They're hiding the rationing that's going on. But there's rationing going on nevertheless.

Bill Curtis: So can I ask this? Howard, does Kaiser have a unique view of how to manage this problem?

Dr. Howard J. Fullman: I think especially from the point of view of Kaiser Permanente, we feel that there are some relatively more simple approaches to health care where it's not all just about spending money on the latest and greatest technology or pharmaceutical. For example, prevention. You know, we in the United States are much more engineered to have patients get great treatment when they're sick, but we're not really engineered to make sure that they get all the preventive care that they should get. And there are.

Bill Curtis: Politically and insurance wise and so when you say engineered

Dr. Howard J. Fullman: Every one of those ways, we first of all, we don't talk about it enough. We don't talk about prevention enough. We don't advocate enough for it. And we don't have financial incentives that favor prevention or financial incentives, favor taking care of people when they get sick. We spend a lot more money per unit time for doctor, etc. when someone is sick then giving them advice on how to prevent them from getting sick. So if we just could get every single American to do the tests and take the treatments from a preventive standpoint that we know work that right there would improve health and that right there would reduce costs. And that was certainly something we at Kaiser Permanente felt very, very strongly about and have tremendous data to show that we've been doing those things in a very, very substantial way, making sure that populations of patients get their mammograms, get their hypertension screens, take basic medications that work for their condition. But you have to make sure that large numbers of patients in the population do it, because of a small percent do it you won't get the same benefits. So one example,

Bill Curtis: So what country does this well?

Dr. Howard J. Fullman: Many countries around the world and in fact, we are starting to do it better in this country. No country does it perfectly, however. In fact, still that's a problem. That's a problem that is actually international in nature. But some countries that are doing better at it include Germany, the United Kingdom, even the National Health Service where people have their criticisms at times about service and whatnot in

the NHS. The NHS does give care that's very evidence based, but no one country has got a monopoly on how to give great prevention. That's just a huge opportunity for us and everybody else as well.

Dr. Steven Taback: Let me give you a negative example from this country, which I'm noticing historically. We do screening blood tests on patients every year. Complete blood count, comprehensive metabolic panel looking at kidney function, liver function, your lipid profile, your cholesterol, your LDL, your HDL, etc.. And historically, this has been paid for by insurance companies, has been paid for by Medicare. Currently Medicare and then subsequently other insurance companies have followed that we will do a blood count if you have a blood disorder. So if you're anemic, we will justify doing a blood count. If you have kidney failure we are justified in running your creatine and your kidney function test. If you have a thyroid disorder, then we will pay for that. But if you don't have that, you don't have any of these disorders. We no longer pay for routine screening, laboratory data.

Bill Curtis: So does that mean that the insurance companies have not adopted the principle that preventative care actually ends up costing them less in the long run?

Dr. Steven Taback: To not pay for these screening blood tests will save millions for private insurance companies as well as for Medicare.

Bill Curtis: So, Howard, you're you're focused on how we create better outcomes for patients. Isn't this part of the problem and what do you suggest we do about it?

Dr. Howard J. Fullman: Yeah. So again, at Kaiser Permanente, we didn't control doctors ordering habits. A doctor can do anything that they think is appropriate for a patient. And we didn't tell them not to order tests and whatnot. But in particular, we strongly encourage them to do things that are evidence based. So if there was a test to be done that would help detect something early, we absolutely want doctors to do that and have a very good record of accomplishing that. And then again, we didn't restrict people from practicing the way they felt was best based upon their view of of the clinical evidence and the patient's condition. However, it's similar to what happens in government when governmental, when when there are tough times and government budgets are challenged, they tend to slash things. They tend to cut because that's the

only way they can balance a budget. So as we get closer to Medicare insolvency and insurance companies are having their own problems with costs, they start getting into a cost savings mode. And those cost saving modes are not necessarily evidence based so that you start maybe cutting out the baby with the bathwater a little bit and don't intelligently try to figure out what you should do and what you should not do. What I'm advocating for is to try to use scientific evidence as much as possible to make thorough assessments of these various technologies or tests and then use the evidence that comes forward and make sure people do get these tests or to get these therapies as opposed to.

Bill Curtis: so basically you want to use this information to convince the health care economic controllers, the insurance companies, to think differently about the process.

Dr. Howard J. Fullman: I do. But I also want to say it's easy to just blame the insurance companies, and I'm not here to be an apologist in any way for insurance companies or explain what they do. Again, I'm very proud of what we did in Kaiser Permanente because we were not just an insurance company, also provider of care, and we have a really good record of quality. But I do think that the opportunities for improving health certainly exist at the insurance level. They exist at the physician level, but they also exist at the patient level. So if we have certain tests that benefit people, we should do a better job of advocating to make sure patients get those tests. And want those tests and do those tests.

Dr. Steven Taback: So let me talk to you about another related problem.

Bill Curtis: That's interesting, create a pool market for tests rather than the doctor saying this is what we expect from you.

Dr. Howard J. Fullman: And not just tests and diet and exercise and vaccinations.

Bill Curtis: oh that, that exercise thing and diet,.

Dr. Howard J. Fullman: Right, those little things, because all of these things have an impact, and this is where there is a difference between us and the rest of the world because we're very much in a drug taking culture. You know, we get anxiety, we take a

drug, we causing anxiety, we take a drug, we eat badly, we take a statin. We need to get into a conversation, this country, to figure out what we stand for, what we want to be and it has to be at the doctor level, at the patient level, the insurance level, not just any one level, because we cannot continue on the current course without bankrupting the country and still not getting the outcomes that we deserve.

Bill Curtis: So is there a poster child country for the citizens understanding that they have to treat themselves differently?

Dr. Howard J. Fullman: No, I don't think so. I think this is a pervasive problem in the industrialized world, but there are better systems in terms of how they're delivering care than ours in certain ways.

Dr. Steven Taback: So one of the examples I was going to give were they are now using evidence based medicine to kind of work against and to act as a barrier to care in the private sector where I've been for the past 28 years, of late and of late meaning the past probably seven, eight years, if I wanted to ordered a CAT scan on a patient who I think has a pulmonary process that warrants a CAT scan, nearly every insurance company, including Medicare, will automatically deny that scan and mandate a peer to peer review under the auspices of this is evidence based. We want to test that you are doing this based on some sort of evidence that will allow you to have the scan. They then force me to speak, to appear, and invariably it will be a specialist in Obi/Gyny or a specialist in endocrinology. Not that they're not well-trained in what they do, but I'm a pulmonary critical care specialist. I would think, maybe not. Maybe they're right. But I would think that I have a better handle on what I need based on my, on the gestalt of my patient and hopefully which is evidence based. But under this auspices, under the auspices of trying to do things that are evidence based, what they have really done is set up a barrier because I get on the phone, I'm on hold for 15 minutes, then I have a peer to peer discussion maybe with somebody for another 10 minutes, 15 minutes. How many doctors are going to take 20, 30 minutes from their day for every CAT scan that they order.

Bill Curtis: So there is no peer review structure at a Kaiser,.

Dr. Howard J. Fullman: No, medical necessity within Kaiser Permanente means whatever the doctor thinks you need, you get it. And that's how we operate. We trust our doctors. We know that they're always trying to do the right thing and we give them the ability to do that.

Bill Curtis: Sounds kind of Utopian.There's no C.F.O. someplace that walks the halls and now creates nightmares for the doctor.

Dr. Howard J. Fullman: No, actually, the doctors really can give unfettered care and they do what they think is right for the patient. And we try to make sure that they do things as evidence based as possible. But no, we don't control.

Dr. Steven Taback: So as head of quality, how did you oversee that? What, if your tenant is the doctor can do what he or she feels is correct, how are you then policing the doctor that might be deviating from what would be evidence based?

Dr. Howard J. Fullman: So we wouldn't call it policing, but we certainly share data. So every doctor would know, let's say my panel of patients with diabetes. This is the average hemoglobin A1C. And if I'm getting really low and really impressive hemoglobin A1C but somebody else is not achieving that. There would be peer to peer instruction and comparison and we would share what we're doing. So we learn from each other. There's often awful lot of health care education that goes on to share these best practices. And we make, put systems in place to make it easy for people to do the thing that benefits the patient the most. So by and large, I don't think that the utilization patterns are so much higher necessarily within a system like ours where people can do what they want. But hopefully there's less variation and people are doing things that are much more scientifically and evidence based. But I will say that and I think the way, Steve, that you described a little bit ago, you know, having a doctor of your stature, you know, all of the education that a specialist has having to waste their time, that's not the answer to this. It's not. And by the way, I remember in the old managed care era, it wasn't peer to peer. It was actually probably speaking to somebody who didn't have a medical education, who was reading from a book. And you had to just describe whether you met the criteria.

Bill Curtis: That sounds like even more fun.

Dr. Howard J. Fullman: So it was, that's what it used to be. And I don't think that's the answer. I don't think we should be gatekeeping.

Dr. Steven Taback: Well, this isn't set up for real evidence based medicine. This is set up as a barrier so that most physicians or at least let's say 50 percent of physicians who say, I don't have time for this.

Dr. Howard J. Fullman: Right.

Dr. Steven Taback: And so they won't make the call. How much money is that going to save the insurance entities at the at the end of the day? Billions of dollars every year.

Dr. Howard J. Fullman: Billions, of course. Right.

Bill Curtis: Is that just because Kaiser is kind of existing in a bubble and they don't have to work with the same parameters as a private hospital?

Dr. Steven Taback: Yeah. Basically, they've created their own bubble. Now they for better or worse, they rise and fall by their decisions economically and medically, but they only have themselves to answer to.

Dr. Howard J. Fullman: And of course, you know every organization. To be fiscally responsible, it isn't, as they say, no margin, no mission, so no matter who you are, you can't spend more than you take in because that's not something that could last forever. But, you know, we'll only scratch the surface on the kinds of things that can be done. We talked at the moment about prevention, but I'll give you some other examples. The amount of chronic disease that we have in the United States is overwhelming at this point. Diabetes, obesity, hypertension. I'm sure Steve can speak to it. He sees it every day in the intensive care unit, people who are now with bad illness because they had these kinds of co-morbidities. And yet so many folks who have these kinds of problems have not been properly cared for before they get desperately ill. They haven't been put on a proper diet. They haven't been put on a basic medication that is inexpensive and works and helps prevent problems. But it takes systems and takes information. It takes data. And with the physicians, it's showing them what's working, what's not, so that they

can get better and better at it and giving them resources around them to help them achieve them.

Bill Curtis: So you mentioned something to me before the show that I'm going to throw back at you, Doctor. You said that the U.S. spends more per capita per patient than any other country and our outcomes don't necessarily show it. So I have to ask you, where's that money going?

Dr. Howard J. Fullman: Right. Well, first of all, that's a very complicated question. So to some extent, we're not spending our money optimally on what works. So we're spending disproportionately money on things that in some cases may not be beneficial, may not work. We're spending a lot of money on people who have very, very advanced disease, older people, people with very severe conditions.

Bill Curtis: So at that point, we should start rationing.

Dr. Howard J. Fullman: No,

Bill Curtis: and not give them the care.

Dr. Howard J. Fullman: No, I don't believe in rationing at all. But I do think that there are times where we can be making perhaps different kinds of decisions and not based on the money, but based upon what's the right care at that time. But at the moment, we have lots.

Bill Curtis: Based on what's the right care for their,

Dr. Howard J. Fullman: For their condition.

Bill Curtis: For their survival?

Dr. Howard J. Fullman: For their condition at the time. And so we have, I'm sure, you know, Steve could tell, can tell stories of many, many patients in intensive care units whose condition is very, very profound. And some people wind up in the intensive care unit for months at a time. And that can be extremely expensive.

Bill Curtis: So you're talking about artificially keeping someone around who's passed their time.

Dr. Howard J. Fullman: And that's not, I don't really believe in that. First of all I don't believe that I can say when someone has passed their time. But I think sometimes doctors can do a better job of talking to patients and families about what their condition is and talking it through. But it's ultimately up to the patient and the family what should be done. And only up to them. But sometimes doctors are resistant to having those conversations. So I think that on the one hand, I don't believe in rationing and I don't think we should ever, ever make our decisions based upon money, including an end of life. But on the other hand, I think we need to make sure that we're educating and talking to our patients appropriately about the conditions at all times in life when they're healthy, when they're not healthy. But going back to your question about where's all the money going? So if you look at the economic incentives, we pay a lot of money to a doctor to do a major operation. But we don't pay them very much money to have to do a physical exam and have a wellness exam on the patient. So how is a doctor in a primary care practice supposed to keep their practice going when doing an extensive history and physical brings them such little money compared to what somebody can make for doing a major procedure? That's not a good distribution of the way we use our money.

Dr. Steven Taback: Are you implying that doctors are being paid more than they should, in this country?

Dr. Howard J. Fullman: Well, I put it this way. We definitely make a lot more per unit everything, per unit time, etc. than most of the rest of the world. I'm not I'm not.

Bill Curtis: Even the physicals? Even the preventative care?

Dr. Howard J. Fullman: Doctors make more in the United States than most other countries, per unit time, per unit, everything. But I'm not an apologist for that. I see what it takes to become a doctor, to be a doctor, the stresses of being a doctor, the value it has. No, I don't think we're overpaid. I just want to see people be paid well in American

health care for all of the work they do, not just a procedure work. I'd like to see doctor be paid well for the cognitive work.

Bill Curtis: So kind of re-allocate how they're paid.

Dr. Howard J. Fullman: I think that would be it. I think that would help to a degree.

Dr. Steven Taback: Have we reached a certain place in America where if reimbursement were to go down any further, are we going to be able to get the the best and the brightest in a field that we think warrants the best and the brightest? Number one.

Dr. Howard J. Fullman: One thing that should be addressed from a public policy standpoint, if you want people to go into any field that they like. Make sure that they can afford to do so and try to avoid having them be so much in debt by going to medical school. That would be one example. By far, we have the highest tuition in the world compared to everybody else.

Dr. Steven Taback: Absolutely

Dr. Howard J. Fullman: And that's, so that's a problem. Tat's something can be addressed as a public policy standpoint and should be.

Bill Curtis: You know what I'm going to ask us for just a minute. We're going to take a quick break. But when we come back, I want to pick up that subject and then I want to talk to you about comparing two bubbles, the bubble of Kaiser, where they're managing their process. But I'm also going to want to compare that with the V.A. that's also in a bubble and ask you about their outcomes. We'll be right back.

Promo - Cars that matter: Hi, I'm Robert Ross, host of Cars That Matter. You might be wondering what makes a car matter and I have a feeling you already know the answer. Some cars have changed history. Some you can hear a mile away. Some have lines that make your heart skip a beat. If a car's ever made you look twice, then I think you know the ones that matter. Join me as I speak with designers, collectors and market

experts about the passions that drive us and the passions we drive. Cars that Matter. Wherever you get your podcasts.

Bill Curtis: So we're back with Dr. Howard J. Fullman and of course, our host, Dr. Steven Taback. Let's go back to that question I asked before the break, comparing outcomes at the V.A. to Kaiser and maybe the rest of the country. What do we know about it?

Dr. Howard J. Fullman: Well, I, first of all, have a tremendous amount of respect for the Veterans Administration. An important mandate, taking care of a veteran. Nothing could be more important than that. You know, we owe so much to our veterans. And I will say that I have gotten some of my training at V.A. hospitals and I'm on the faculty UCLA, and partly teach at the Wadsworth VA Hospital. So I've seen some fantastic medical care and some very devoted doctors and nurses who try really hard to take care of the patients and do so well. They have made a tremendous investment in electronic medical record before anybody else did. They had one of the most evolved electronic medical records and did that across the country. And that was a big gamble and a big investment on their part that actually did pay off quite a lot. But I think to a significant degree, the V.A. may be under-resourced, especially given the number of people coming out of the military in recent years and as well as the prevalence of some very important conditions, including post-traumatic stress disorder, which is extremely prevalent amongst our veterans. And nobody has a good answer to it. And even our mental health system outside of the V.A. is inadequate in the United States with way insufficient resources. And I think the V.A. is trying to figure out how to take care of so many people who have so much illness within the budgetary constraints that they have. And I want to applaud the V.A., because I think they're taking a very dispassionate look at the way they're providing care and trying to re-engineer the way they give care. And I think they're going to improve over time, but it's going to take some work and probably some higher levels of budgets to get us there.

Bill Curtis: So with all the challenges that they've got, the reality, of course, is they are funded with the same type of mechanism that Medicare is funded, correct?

Dr. Howard J. Fullman: They are, except that it's a little different in the sense that, you know, Medicare gets its funding from payroll taxes as people are working. And that's

what they have. Whereas the V.A. gets its, you know, it's funding from whatever legislative, whatever is legislatively approved by Congress. So Congress could change the level of the VA funding, you know, quarter by quarter and do so at a much higher level where it's a little more difficult to do that with Medicare, which is related to your payroll taxes.

Dr. Steven Taback: But any physician, I think, that has been trained in the United States has spent a fair amount of time in a V.A. system. And I think everybody has been impressed by the level of service that is being delivered in a very, as you stated, in a very under-resourced environment. There's only so much money to go around. And so many veterans with such complex care issues from Agent Orange and psychiatric issues relative to post-traumatic stress disorder that I think they do a great job. I would have to echo that, but also echo the fact that they are sadly under-resourced. And we've always felt that as ,when we were in in med school and doing our rotations through the V.A.

Dr. Howard J. Fullman: The other thing I would also say about the V.A. is that as Steve alluded to but should be stated very, very directly is that the Veterans Administration does a fantastic job training doctors around the country and has made a huge contribution that way. And a lot of research is done at the V.A. hospitals. So, again, I want to applaud the V.A. I think they do an excellent job. They try very hard. Nothing could be more important than their work. We should all be very grateful and respectful to the work they do. But we also should make sure we're being supportive so that they can do even better.

Bill Curtis: Okay. Well, let's talk about a couple of different specialties. Heart, for example. We've gotten a whole lot less invasive in a lot of our heart procedures. Aren't our outcomes a whole lot better these days than they were even five years ago,.

Dr. Steven Taback: Markedly improved. And it's not just our outcomes relative to mortality, but our outcomes in terms of trauma, both physical and psychological to the patient. If you can put a heart valve in with minimal invasive procedure as opposed to cracking somebody's chest open, that's huge. Or actually a good friend of mine has recently had a valve replacement because she had a terrible case of endocarditis and valve destruction and she lived long enough now with her heart valve to be able to take

advantage of the new technology that allowed the percutaneous valve placement. So there is so much going on that improves quality of life, that minimizes the invasive procedure and the pain and suffering. And it's not just outcomes and certainly outcomes mortality have improved. But the other side of diminishing the trauma the patients have to undergo for procedures has markedly improved as well.

Dr. Howard J. Fullman: And I'd like to add to that that patients who in the past would not have been able to receive any kind of treatment for a certain condition because that treatment would have been too invasive and too risky for them given their condition can now get a less invasive approach and not just have have less trauma, but actually survive that maybe when they wouldn't have even been a candidate for the procedures. Well, so that these are huge developments and cardiology is one great example of that, doing that in such important ways.

Dr. Steven Taback: Right, one of our strategies in private practice and in practice, in medicine in general, is get your patients to live long enough to catch up with it, so the technology will catch up with your disease. And it's really true. I mean, if you can keep somebody alive with today's cancer treatment long enough so that when a cure is now available for their particular type of cancer, you've done a tremendous service. So it's, you want to keep the game going long enough so that finally you can get to the cure, hopefully within within our lifetime these cures will become available for a whole host of of medical illnesses.

Bill Curtis: So getting back to the outcomes for heart, for example, where I'm going to tie in your previous subject where you talked about preventative, one of the things that you guys have done clearly with the technology of preventative care for heart is you're managing people's blood pressure more than ever, right? In part, but part of that is medication. So I have to go back to cost for just a second because, and now this works for all medication,I know, but comparing pharmaceuticals related to controlling blood pressure. Look at the cost of those pharmaceuticals here in the U.S. versus just about every other country on the planet. Explain to me why there's such a difference.

Dr. Howard J. Fullman: Well, first of all, I think it's important to point out there is an enormous difference. Pharmaceuticals developed in United States, manufactured in United States are often way more expensive here in United States than those same

drugs made in our factories and developed here, sold in Europe. But there's a lot of other elements. It's not first of all, it's not a functioning market. So.

Bill Curtis: What does that mean?

Dr. Howard J. Fullman: Well, there's not the usual laws of supply and demand. We give the pharmaceutical companies long patents, which means they're the only supplier. Even when the drugs go to generic, there's sometimes only one generic manufacturer. So it's really almost the same as when they were on brand.

Bill Curtis: It becomes a duopoly.

Dr. Howard J. Fullman: We let them have direct to market advertising, even for biologic medications, for complicated illnesses, which no other country does. And we have insurance pay for a good amount of the cost. So the individual person doesn't see it. They don't necessarily pay it. So when you add those factors up, that's a recipe for escalating and very skyrocketing costs, which is what we have in United States. And by the way, when you talk about where the money is going, that's a big part of where the money is going. We now are spending more on pharmaceutical costs than we are on physician fees in the United States. And that's true for Medicare and every other insurer. And they're going up at a much higher rate. Part of the answer is start making pharmaceuticals act more like a true market where there's supply and demand and competition. Think you can have the patents be a lot less long and be a lot shorter would be one thing to do.

Bill Curtis: So, if I were a pharmaceutical company, how could I make sense of the economics of getting a drug past the FDA?

Dr. Howard J. Fullman: They'll make plenty of money with a shorter patent cycle. You make it easier for the for the generic manufacturers to get going for multiple ones to make drugs and give them incentives to to do so. Limit some of the advertising for biologics and some of these incredibly expensive drugs. There's no reason why those should be on television. In my opinion, I think it's ridiculous for a patient to come in and say, I think I should have this immunotherapy .

Bill Curtis: You realize you're talking to somebody in the media, right?

Dr. Howard J. Fullman: I do.

Dr. Steven Taback: But it's two against one. And we concur so you're outnumbered.

Bill Curtis: So I guess what I don't understand is, getting political for just a second, I'm not sure how many lobbyists are in Washington related to this subject, but it's more than a handful. It's probably I mean, strikingly, it's probably thousands of people that are lobbying these concepts in Washington.

Dr. Steven Taback: And it works because it's whatever the market will bear. Why would the same medication be 50 percent as much in Canada and maybe 20 or 10 percent as much in Mexico?

Bill Curtis: So why do we keep hearing silly stuff, if you don't mind me saying, free health care for all, free tuition for all? Why aren't we hearing more specific solutions like let's stop wasting money by giving so much money to the stockholder, to the pharmaceutical companies?

Dr. Steven Taback: I think it's because, you know, from my perspective, that solution is very complicated. How are you going to speak to the populace about what you're talking about in terms of talking to the shareholders, minimizing, you know, their returns so that it reflects something that is more reasonable.

Bill Curtis: We just did it pretty quickly. It didn't seem that complicated.

Dr. Steven Taback: Well, it's more complicated than that. It's easier when you're trying to get elected to say free health care for everybody because everybody wants to hear about that. Everybody would like to believe that that's something that can can be attained. And I think the average person in this country would say, OK, if somebody says it can be done, I'm going to go with that person without thinking realistically is that really something that can take place? So there are platitudes and then there's reality. One of the purposes of this show is to talk reality. Right. I mean, that's what we're here for. To try to educate the public, try to discuss these difficult and complex issues. But

this utopian society where free health care for everybody, free tuition for everybody. Maybe there's a way to make that happen. I'm not sure. But to just say that, in a very blanket statement, that this is something simple that's not going to require a lot of engineering would be a misrepresentation.

Bill Curtis: So Howard I have to ask you, you know, as an example, I'm told that pretty much all men there's a race between our life span and the likelihood of our prostate causing a problem. Right? And we were all supposed to deal with that. And now the question is, do I get hit by a bus before that or is that actually going to show up? So if the prostate is going to be a problem, if I want free health care. Fine. I still want my prostate surgery to be done by a Davinci robot with someone who's trained to do that, sitting on the other side of the room and using the absolute cutting edge technology. Isn't that the case? So is that a lot more expensive to conduct that kind of surgery?

Dr. Howard J. Fullman: Well, actually, no, not that much more. It's somewhat more. So I am very familiar with the Davinci robot and actually the first Davinci robot in Southern California. Kaiser Permanente was at my medical center. So we actually developed the program for robotic surgery on prostate cancer. Very proud of the record that our surgeons created. They're fantastic, amazing outcomes with high cure rates and low, low side effect rates. How do you do it? You.

Bill Curtis: I mean isn't it part of outcomes, though, is that you, It's not necessarily the surgery that's better. It's the side effects.

Dr. Howard J. Fullman: Yes, that's right. So, I mean, a good outcome means high cure rate and low side effects. And in the case of prostate cancer, the use of The Davinci robot by a skilled surgeon who's familiar with how to do the operation does and with proper case selection, making sure people who really benefit from it are the ones getting the surgery. The results are extraordinary. And you would want that and should want that. And most Americans have access to that. So that's an area, by the way, where we're actually doing quite well in United States. Cancer care in general, we're doing quite well. We've actually cut mortality for several cancers in the United States. Lung cancer is one. And melanoma has been actually cut in the last couple of years. So, you know, Steve earlier was talking about cancer. Now its often more like a chronic illness. It's not necessarily an acute illness in the way we used to think of it or an

episodic illness. It's actually something where we can actually suppress, maybe not always cure cancer, but we can keep people alive and relatively healthy for long periods of time until perhaps something better comes along that perhaps can even cure them of their condition. So there's no doubt that when it comes to more significant problems like, let's say, prostate cancer or cardiovascular disease in the United States, we largely do pretty well. And that's an example where investing in the right resources and investing in the right training to get people proper, the proper people doing this and the right equipment has real benefits to patients.

Dr. Steven Taback: But yet there's some insurance companies that will not allow you to have the Davinci. If there's something that's more simple, that's simpler and less expensive and there will always be at least a two tier system in this country with those people who have the means that are going to get the best, the brightest, the latest technology and will travel the country to doctor shop, to technology shop. And so to say that everybody is going to be painted with the same brush, that everybody is going to be able to receive the same level of care, not very realistic, I don't think, in probably in any country, any industrialized country, but certainly the disparities are always going to be greater in the United States.

Dr. Howard J. Fullman: Yeah, I agree. I agree with that. And maybe my answer before is a little bit utopian. But I do think generally if people have insurance in the United States, they generally have access to pretty good care. Now, what's more deplorable is the number of people in the United States who don't have access to insurance.

Dr. Steven Taback: Exactly.

Dr. Howard J. Fullman: Think about if you're one of those 50, 60 million people who doesn't have access to care and what that really means. And so there's not one road to universal care. There's multiple roads, but they don't all have to be public. They can be private and public. And I think the concept that it's all just going to get paid for by a massive expansion of Medicare for the reasons stated, I don't think that that's very politically tenable and not supported probably by the average American. I do also want to say, you know, you're asking about the systems around the world. We've been discussing the health care system in isolation as though it exists in a vacuum and nothing else matters. It's all how we fund medicine and medical care. Right. But a big

part of outcomes in health care have a lot to do with what are called social determinants of care, which means how much poverty do you have, how much food insecurity do you have, how much housing and security. If you look at Los Angeles, where we have massive homelessness, what's the effect on the health of those folks? So no matter whether they have health care coverage or not, and presumably many of those folks do not. But if you don't have a house, you don't have a home, a place, you don't have shelter, you don't have food, that also has a pretty darn big impact on health care outcomes.

Bill Curtis: In other there are other countries that are handling that issue better.

Dr. Howard J. Fullman: I think if you look at the data we spend the most on health care. We don't necessarily have the best healthcare outcomes, but we also spend the least on social support. Now that takes different forms in different countries and I don't consider myself an authority to be able to tell you which system is better. But I do believe paying attention to these other aspects of people's lives has a major impact on their health care outcomes.

Dr. Steven Taback: And it's interesting because I think if you ask the general population, the number of people who would say, you know what? I think there should be health care for everybody, that everybody should have an equal and high level of health care. I think the vast majority of people in this country would say yes. I think that would be a good idea. And yet we don't live our lives that way. We don't structure our country and our policies that way. And I think in some ways we're kind of stuck because of the history of our expectations.

Bill Curtis: As we bring this to a close, what grade would you give us now in America for our outcomes?

Dr. Howard J. Fullman: I'll be generous. I'd say overall, give us a B and Canada. I would give Canada a B on outcomes and a C plus or C on service.

Bill Curtis: Sounds like Germany is going to get a higher grade.

Dr. Howard J. Fullman: I like the German system alot. It's one of my favorites.

Bill Curtis: Dr. Howard J. Fullman, we thank you for joining us. And of course, Dr. Steven Taback, thank you for hosting this. And next time, if you'd come back and tell us a little about Atlantic Street Capital and some of the cool investments in the medical industry that you're working on and how that's going to change the outcomes for the American people.

Dr. Howard J. Fullman: Happy to Bill, thanks.

Bill Curtis: Thanks for joining us. Come back and visit Medicine. We're still Practicing. We'll see you again next time.

Bill Curtis: If you like what you hear. Please tell your friends and let us know how we're doing by leaving a comment. It really helps if you give us a five star rating and we really appreciate it. You can also subscribe to the show on Apple podcast, Stitcher or wherever you listen to your favorite podcast. This episode was produced and edited by Mike Thomas. Audio Engineering by Michael Kennedy. And the theme music was composed and performed by Celeste and Eric Dick. Thanks for listening.

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