is a great need and opportunity for credible state-level policy think tanks and foundations to step up and play this role.

Conversations in Colorado and Kansas suggest that the new ground to be broken in health policy involves a focus on the social determinants of health and developing a common language for discussing health care costs. Shared understanding of the problems and goals may create opportunities for bipartisan collaboration, policy innovation, and difficult conversations about the role of government — if state officials are willing to take risks. Then, if history repeats itself, their efforts will show the way for that lagging legislature in the District of Columbia.

An audio interview with Dr. Jones is available at NEJM.org

Disclosure forms provided by the authors are available at NEJM.org.

From the Department of Health Law, Policy, and Management, Boston University School of Public Health, Boston (D.K.J.); the Clinical Operational Research Unit, University College London, London (C.P.); and the Milbank Memorial Fund, New York (C.F.K.).

1. Greenblatt A. "Not exactly a blowout": Democrats score modest gains in state legislatures. Governing, November 7, 2018 (http://www.governing.com/topics/politics/gov-democrats-state-legislatures-2018-midterm-elections-trump.html).
2. Pagel C, Bates DW, Goldmann D, Koller CF. A way forward for bipartisan health reform? Democrat and Republican state legislator priorities for the goals of health policy. Am J Public Health 2017;107:1601-3.
3. Jones DK. Views from the heartland: prospects for bipartisanship in health reform. New York: Milbank Memorial Fund, April 26, 2018 (https://www.milbank.org/publications/views-from-the-heartland-prospects-for-bipartisanship-in-health-reform/).
4. Zhu JM, Chhabra M, Grande D. Concise research report: the future of Medicaid: state legislator views on policy waivers. J Gen Intern Med 2018;33:999-1001.

DOI: 10.1056/NEJMp1809153
Copyright © 2018 Massachusetts Medical Society.

Politics and Pandemics

Ron Klain, J.D.

This year marks the 100th anniversary of the deadliest event in U.S. history: the Spanish influenza epidemic of 1918, which killed more Americans than World Wars I and II combined. Although science and technology have advanced tremendously over the past century, the pandemic peril remains: a recent exercise at the Johns Hopkins Center for Health Security showed that an epidemic of an influenza-like virus could kill 15 million Americans in a single year.

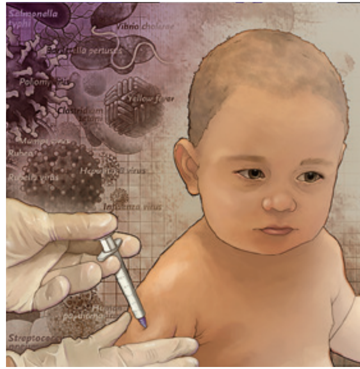
The medical community's response to this danger is, understandably, focused on research and response — discovering new vaccines, therapeutics, and diagnostics and fighting ongoing epidemics, such as the current Ebola outbreak in the Democratic Republic of Congo (DRC). But these urgent undertakings are not sufficient. If the world is to tackle many factors that raise our risk of a devastating pandemic, the medical community may have to enter theatres of operation beyond the laboratory bench and the treatment unit and publicly engage with controversial issues that some observers would consider nonmedical. Indeed, I believe that only such efforts can save us from the social trends, political movements, and policy failures that are elevating our risk of a pandemic.

Of course, the social trend that has most increased that risk is also the most beneficial: the vast increase in global connectedness attributable to improvements in transportation and infrastructure. Today, it would take less than 24 hours for a virus like the 1918 influenza to move from almost any point on the planet to Paris or Washington, Beijing or Riyadh. Yet the benefits of global connectedness are too important, and the transportation revolution would be impossible to reverse even if we wanted to.

But what about less beneficial changes and trends that are making us less safe? There are three in particular in which the medical community's intervention is sorely needed.

First is the rising tide of isolationism and xenophobia — a turn inward — in many high-income nations, particularly the United States and European countries. A nationalistic mindset — with leaders telling us that global engagement is not our responsibility and proposing the retrenchment of our commitment to global health security — makes all countries less safe with regard to pandemic prevention and response. The belief that isolating ourselves from the world can prevent the spread of diseases is foolhardy: we can build no wall high enough to keep out infectious diseases and disease-bearing

The New England Journal of Medicine
Downloaded from nejm.org at VA LIBRARY NETWORK on February 8, 2022. For personal use only. No other uses without permission.
Copyright © 2018 Massachusetts Medical Society. All rights reserved.



vectors. Though the U.S. Congress has thus far rejected proposals to slash international programs at the National Institutes of Health and the Centers for Disease Control and Prevention (CDC) in order to fund a border wall,[1] the pressure to do so continues.

We have already seen the consequences of such thinking. In 2016, xenophobic sentiments on Capitol Hill played a key role in delaying a U.S. response to Zika. Critics stalled the package, saying (in essence), "Zika is an immigrants' disease; just keep the foreigners out." Because of the funding delay, we saw local Zika transmission in Florida and the first-ever CDC advisory against travel to a part of the continental United States.

The second trend is the growing tide of antiscientific thinking and resistance to evidence-based medicine — often associated with surging populism and manifesting in the rise of the antivaccination movement. In low-income countries, skepticism about vaccines is a perennial challenge, but what we are seeing in the United States and Europe is something very different, and very dangerous. The growing refusal of parents in high-income countries (particularly the United States and Italy) to vaccinate their children[2] is the tip of an iceberg that could sink us all in the event of an epidemic demanding rapid vaccine deployment and acceptance. It is a product of a political movement that includes left-wing populists who deem vaccines to be "unnatural" corporate products and right-wing populists who reject vaccination to spite the "elites" who promote it.

Third, there is disease-related danger from climate change.[3] Climate-related destruction of habitats forces wildlife and humans to live in closer quarters, creating new risks of transmission of zoonotic diseases to humans. Climate change also creates refugees who are vulnerable to the rapid spread of infectious diseases. And changing climate allows for migration of disease-bearing vectors — such as *Aedes aegypti* mosquitoes — to new locales, putting new (and larger) populations at risk.

What can the medical community do in the face of these threats? All these dangers, in my view, require medical professionals to become more politically engaged. This responsibility is not a question of aligning with a particular political party or candidate. There is a broad need to match a bold commitment to research and science with an equal focus on changing minds and hearts and creating a social and policy framework that can help prevent future epidemics and make future responses more effective.

The medical community can begin by stepping up pressure on policymakers to adopt the measures needed to improve our preparations for and ability to respond to epidemics. These policies include a much larger Public Health Emergency Fund, a reversal of recent reductions in funding for domestic epidemic preparedness, and changes in the Stafford Act to allow the President to declare a "major disaster" arising from an infectious disease outbreak. Perhaps most important, physicians can insist that the United States continue to invest in global health security and assistance to countries that are trying to improve their own response capabilities, even when such foreign aid is unpopular.

In addition, physicians can advocate for and provide counsel about building out and improving our global response systems. Today, when an outbreak occurs in a country with a weak national health system, the global response relies on the World Health Organization and a network of courageous — but private and voluntary — nongovernmental organizations. In a pandemic, an effective global response would exceed the

The New England Journal of Medicine
Downloaded from nejm.org at VA LIBRARY NETWORK on February 8, 2022. For personal use only. No other uses without permission.
Copyright © 2018 Massachusetts Medical Society. All rights reserved.

capacity of the former and lean far too heavily on the latter. A more robust global response mechanism is needed. Such a mechanism will need to include a security-equipped epidemic-response unit that can operate in dangerous conditions such as those currently impeding the Ebola response in the DRC.[4]

Finally, and perhaps most fundamentally, medical professionals can step into the public arena to take on unpleasant and contentious political issues such as isolationism, climate change, and demagogic populism. Many members of the medical community prefer to avoid becoming entangled in divisive issues that seem to be outside the scope of medical concerns, but their voices are needed to confront xenophobia,[5] rejection of science, and populist hostility toward expertise. Grappling with climate change cannot be left to environmental experts alone — it is a medical issue as well. Health professionals have a knowledge and gravitas that should not be restricted to academic conferences and journals; the public conversation would benefit from their voices in the mainstream press and even on social media. The "virus" that kills millions may not be one that can be stopped in a laboratory: it may be a false Tweet or Facebook post that "goes viral" and puts countless people at risk.

Four years ago, when I — a government official with no scientific training — was put in charge of coordinating policy for and execution of the U.S. response to Ebola (I served as the White House Ebola Response Coordinator from 2014 to 2015), I was ridiculed and belittled, even featured in a humiliating sketch on *Saturday Night Live*. But medical leaders told me to hang in there and do my job (which was largely to help them do theirs).

Now, we need the medical community to take on the criticism and controversy, the unpleasantness and attacks, and to step into the halls of Congress, the offices of the executive branch, and the public arena in order to win passage of key policies and to confront the social and political trends that are making global health less secure. The men and women of this community are in a position to help make us all safer by wading into difficult and divisive issues that are undermining our global capacity to face down a future pandemic.

Disclosure forms provided by the author are available at NEJM.org.

From Harvard Law School, Cambridge, MA. Mr. Klain was the White House Ebola Response Coordinator from 2014 to 2015.

This article was published on November 7, 2018, at NEJM.org.

1. Soffen K, Lu D. What Trump cut in his agency budgets. Washington Post. May 23, 2017 (https://www.washingtonpost.com/graphics/politics/trump-presidential-budget-2018-proposal/).
2. Olive JK, Hotez PJ, Damania A, Nolan MS. The state of the antivaccine movement in the United States: a focused examination of nonmedical exemptions in states and counties. PLoS Med 2018;15(6):e1002578.
3. Shuman EK. Global climate change and infectious diseases. Int J Occup Environ Med 2011;2:11-9.
4. Schnirring L. DRC Ebola cases top 200 as security problems fuel the spike. Center for Infectious Disease Research and Policy. October 12, 2018 (http://www.cidrap.umn.edu/news-perspective/2018/10/drc-ebola-cases-top-200-security-problems-fuel-spike).
5. Rogers A. Calling the caravan's migrants "diseased" is a classic xenophobic move. Wired. October 31, 2018 (https://www.wired.com/story/calling-the-caravans-migrants-diseased-is-a-classic-xenophobic-move/).

DOI: 10.1056/NEJMp1813905

Copyright © 2018 Massachusetts Medical Society.

Toward Precision Policy — The Case of Cardiovascular Care

Rishi K. Wadhera, M.D., M.P.P., and Deepak L. Bhatt, M.D., M.P.H.

The U.S. health care system is in the midst of a transition toward delivery of high-value rather than volume-based health care. As part of this shift, policies that offer incentives to physicians and hospitals to deliver better-quality care at lower cost are being implemented nationwide. Cardiovascular conditions and procedures, which are both common and expensive, have frequently been targeted by these efforts. Given that such initiatives were rolled out with little evidence to support their efficacy, it is not surprising that many have failed to improve the quality of care or patient outcomes. Unfortunately, some such efforts have also had unintended consequences.

Pay-for-performance initiatives, for example, were pushed by policymakers as a means to improve care for cardiovascular conditions, among others, despite minimal evidence that they were effective. These programs have not reduced the rates of death due to acute myocardial infarction or heart failure, even though these mortality measures are used to evaluate hospitals' performance.

The New England Journal of Medicine
Downloaded from nejm.org at VA LIBRARY NETWORK on February 8, 2022. For personal use only. No other uses without permission.
Copyright © 2018 Massachusetts Medical Society. All rights reserved.