Paving a New Path for Health Care: A Conversation with FDA Commissioner Marty Makary and CMS Administrator Mehmet Oz

Esther Krofah 00:20

Good morning everyone. Thank you so much for joining us. Dr. Makary, Dr. Oz. We are delighted that you are here at our Future of Health Summit and our theme, of course, is in service of better health. We have 30 minutes for this discussion, so we have a lot to cover in this amount of time. I want to actually start with you, Dr. Oz. Obviously, we have seen a tremendous amount from this administration on the affordability of medicines for patients. Back to our theme here, in service of better health, certainly seeing the announcements between Pfizer and AstraZeneca as we're really thinking about affordability on behalf of patients. Should we expect more of those?

Mehmet Oz 00:59

Yes, we should expect more of them. Marty and I, secretary, have worked hard, but the folks who really have been remarkable are individuals, many like yourselves, who came in from the private sector. Chris Klomp, I think of John Brooks, Ed Hernandez, who decided that this was an opportunity, maybe once in a lifetime, opportunity, to make a difference in areas where we thought we could do better. And just to set the stage for this, when these individuals, and someone like Chris Klomp built Collective, you know, it was billion dollar business, decided to do all the things you have to do to come into government, and has taken charge of thinking differently about the whole negotiated strategy. And here was the argument that was made on MFN. The president been very vocal about this for many years. It is something inherently unfair if a product, especially if it's made in this country, put in the same bottle, the same packaging, when sold in Europe, is one-third the price that's when it's sold here. It just doesn't feel right. Analogous to NATO when you are defending yourself against an external threat, everyone's got to ante up. And if it's not done fairly, then at some point, in this case, the United States said that's enough. You guys got to put more money in 5 percent contribution of your GDP, or we're not going to fund the entire kit and caboodle anymore. It's

similar to an internal threat, cancer, autoimmune problems, issues that could threaten humanity. It's again, it's a global crisis illness. We have to fight it globally, and folks who can have the most influence should put up little extra, but there shouldn't be a three to one ratio. The United States pays for more than half of all drug innovation. This most favored nation drug pricing came about because pharmaceutical companies voluntarily recognized it wasn't sustainable. I think that's an important message here, and a theme of our administration. We can pass legislation. It tends to be sometimes clunky, powerful, but not always as nimble as you'd like it to be. There's rule making abilities that FDA, CMS, all our agencies, have. Again, it's, you know, takes a while and sometimes not as nimble. Or you can have industry do it. And if they know that everyone's watching and they're desirous of making their industry sustainably, enduringly innovative and successful, they'll respond. And we've seen it with the most favored nation drug pricing now with a leading US company, Pfizer, a leading European company, AstraZeneca, the fertility business. There's more coming again to answer your question, but I think part of it also is recognizing there's the other areas, like prior authorization, which is a widely disliked process, but effective at reducing costs, but a process that interferes with the covenant that doctors have with their patients, and private-sector insurance companies have taken that automated commitment to dramatically change a fixable problem. As long as people felt they had to fix it, they'll fix it.

Esther Krofah 03:49

Yeah, and affordability is also the area of priority for you. Dr Makary, from an FDA perspective, how are you thinking about addressing this issue? We saw the announcement around biosimilars. Maybe you want to talk a little bit more about how you think about the role of regulation and guidance, as you've described, but being clear so that product developers know what's coming and we're really able to meet the needs of American people.

Marty Makary 04:12

Great. Well, thank you. Esther, it's great to be here at my first Milken conference. So welcome. Thank you. It's great to be here.

Mehmet Oz 04:19

They leave scars.

Marty Makary 04:20

I see a lot of familiar faces here, and we don't directly set drug prices at the FDA, but we work in very close collaboration. The part of the job I did not expect is the part that I enjoy the most, and that is to be able to talk to Dr. Oz and to the head of the NIH and the secretary every day. And we are not talking about football, although sometimes that comes up. We are talking about how to lower drug prices for

everyday Americans and how to do meaningful research and deliver more cures that are more accessible to everyday Americans. Look, we have both been at the bedside and we've had hard conversations where somebody asks us, is there anything out there? We have had to say not that we know of. That's a very hard position, and that has an imprint on your mind that lasts a long time. And so we are driven towards this goal of more cures and meaningful treatments and more accessibility, and part of that is affordability, and there's probably no greater priority right now that we have in the health side than to lower drug prices. And we're getting it done. We're both surgeons, and so we like to get things done and do things with the information we have at hand that we have to do that every day at the bedside. So on the biosimilar side, we need more competition. We need more biosimilars right now, it takes an embarrassing five to eight years for a biosimilar come to market. We announced we are cutting some of the requirements to reduce that down in half, two and a half to five years, and you are going to see more biosimilars. We are also reducing the cost required to bring a biosimilar to market by about $100 million or more, depending on the medication that for some companies, it's only $200 million to bring a biosimilar to market. Now, biosimilars, just so, if you do not know, are basically the generic version of the expensive biosimilars. So look, health-care inflation is growing, and it's been growing every year out of pace with inflation in the general economy. The fastest area of health-care spending growth is drug spending, and the fastest area of drug spending is these new, expensive biosimilars. There are only 5 percent of the drugs, but over half of the spend, so we are bringing these generic equivalents. And so I think that was a huge win, and I think everyone's going to benefit.

Esther Krofah 06:55

Absolutely, one of the things that we have been talking about throughout the conference, and Dr. Oz, you and I have talked about this as well in prior meetings and discussions, is that in the US, we spend $4.9 trillion on health care, and our outcomes do not match peer countries, right? On average, even life expectancy about four years below peer countries. And so the work that you are doing on the affordability of medicines absolutely contributes to that. We are in the middle of an open enrollment period for ACA. We are thinking about how Americans are covered. What is the affordability they see with their plans? How do you think about this overall picture, like, where are we in the country relative to all that we are spending, the outcomes that we are driving? And how do we just get everyday Americans to get access to coverage and ensure better health?

Mehmet Oz 07:41

Well, we run the risk in the current tempest of becoming one massive health-care system with a small country attached. The growth rates in the private sector, commercial sector, which we do not regulate. HRSA is in that space is about 9 percent Medicare, same number, roughly. Medicaid, a little less growth, but still growing at a very healthy clip, even after the one big, big, beautiful bill issues are addressed and the ACA likewise, growing quickly. It was flat for a couple years, in part because there were so many people being added to the rolls unknowingly. These are people that probably were fraudulently added without their knowledge by duplicitous brokers. I say that, by the way, because we estimate 6 million out of the 24 million in the ACA don't really know they have those policies or don't use them, only half the people in the ACA file a claim. Most people, if they have insurance, they'll buy their medications with it.

They'll do something with it. So these are numbers that are have been alarming to us. So part of the problem is the actual cost of care is going up. Pharmaceuticals, hospital costs are actually the fastest growing at CMS. But these numbers are addressable if we deal with some of the underlying, underpinning issues within the system, which is why I'm optimistic. As an example, obesity and obesity-related complications explain about a quarter of the total health care bill. They're about half of all chronic illness. And so that's a big number. We think administrative costs are probably 12 percent of the total $1.75 trillion that CMS administers, big number, fraud, waste and abuse, probably about $100 billion you know, 8 percent roughly, of the total bill. These are big chunks that are addressable, and we've taken steps to do some of these things. I'll give you an example. Next year, we projected that the average Medicare beneficiary would pay $40 extra in premiums. It's a lot. It's $200 now, go to $240 unless we dealt with skin substitutes. How many of you know what skin substitutes are? Put your hands up. We spend $23 billion. You don't count, Marty, please. $23 billion projected next year on skin substitutes. Some of these are wonderful tools to close the ulcers on non-healing chronic venous insufficiency. But there's some good reasons for this industry to exist. Obviously, that's why it was there. But it went from being a quarter billion dollars to $23 billion projected next year in five years, and much of it was done fraudulently, because FDA doesn't regulate skin substitutes. So these guys could sneak in with products that really don't seem to be much better than the other products. And because in that space, doctors get paid 6 percent of the price of the skin substitute, they prefer the $5,000 version, not the $100 version. Skin substitutes in Europe are $40 by the way, $40. We are paying $5,000 for the same product. You can see what people sales forces get involved. Companies start to rev up, and we start on Friday evening. We shut that down with a rule that our traditional annual rule that will no longer allow that after January 1. So there are things we can do that historically had not been done, that we are taking action on. And I do think because of that, and because some of things we'll talk about later in this conversation, there's a lot of optimism to be had, but we are not going to be able to get Americans happy with the health-care costs that they're paying unless we actually reduce the cost of health care.

Esther Krofah 11:13

Well, data modernization is a big part of how you're thinking of doing that. You have a platform, and you've worked with a lot of the private-sector companies where you focused on, can we bring the tech ecosystem to play? Can we enable better use of AI? Can we inform patients to use their own data to pursue health care, lifestyles, nutrition, diet, exercise? You made those announcements. How is that going? How are companies responding even to your RFI that you announced in May, allowing so many different stakeholders to respond. Did you get ideas that can make a difference? Exactly what you talked about, bending that cost curve?

Mehmet Oz 11:48

Esther, the response has been overwhelming. I would put some numbers on this. We had an event at the White House on the 30th of July where we brought the first 60 big tech companies, all the big companies you could probably name off top of your head were there signing a pledge to Marty, me, Jay, the secretary, but the president hosted it. The president was the reason they came, and they pledged to do some of the things that have been asked of them for years: data, interoperability, transparency, tools to

help Americans use their own health information more effectively. The conceptual, leading concept is that you own your data. You paid for it, your medical data, therefore you should be able to get it, use it as you wish, give it to an app developer if they want to, or an app company that's developed a tool to help you manage your diabetes or your renal dysfunction, or whatever the problem may be. And we want to get that ecosystem to be healthy enough and robust enough to grow and prosper and allow tools for Americans to better their health. And this digital transformation is dependent on a few realities. The first is, you need companies to get involved. So those 60 companies that started the ball rolling now have ballooned to 450 companies who have signed that pledge. We have another gathering next week with these large companies to start showcasing some of the things they've been achieving. Government has to build some guardrails. For example, how do I know who you are? How do you authenticate that you're that person who's getting those medical records? We're helping build those identifier systems with things like, clearly, they're commercial companies in this space. We're working with a bunch of them, ID.me, etc. We need a provider directory. How do you know your doctor practices in the hospital that you go to? Is that, you know, is that a doctor actually someone who can give you care in a health-care plan? We are helping build a national provider directory that aggregates some of the companies that have been trying to do this, but again, the government will do it for free, just to make sure we have something that companies can crutch on, and then many who have participated in contributing to this. But most importantly, we're able to recruit top-tier engineers. When Marty and I entered HHS, I don't know how many engineers you had, but we had 13 at CMS, 13 engineers.

Esther Krofah 14:01

Amy Gleason talked about this late yesterday afternoon.

Mehmet Oz 14:04

Amy is leading the charge, who's just a whiz at this, and runs US digital service and US DOGE. But when she came to me and said, I have 13 people to run 46,000 employees and contractors, what that really means, Esther, this is a critical issue, is you have someone from HR at the government managing a government relations person at the tech company. The engineers aren't talking and that's how things happen that really bother you. When we came in there, one of the first things we did was do an audit of a lot of our contractors. We fired it. We fired about $3 billion worth of contracts, but we got rid of a contractor who had a five-year contract we'd spend $200 million on not one usable line, and when we fired them, do you know what they said? Nothing. You caught us, and that was it, and you have no recourse. And so these aren't gonna, these aren't tolerable. They're not gonna happen anymore. We have tools, and most importantly, people who are passionate about this. And what Amy has done more than anything else is hire people, hire engineers, top-tier folks coming in off the sidelines for short periods of time, come in for two years, fix the problem, go back and change the world in the private sector.

Esther Krofah 15:11

Dr. Makary, modernization is also a priority for you. You've issued a number of announcements as well food safety, rare diseases. You've talked about AI and the use of that enabling even the first review of a product at FDA. So as you're looking across all of these different initiatives, what's the greatest opportunity to improve patient experience?

Marty Makary 15:33

I think we we have to challenge deeply held assumptions if you don't care about the operations of the agency or the impact you can have. The job is very easy. You can just show up at cocktail receptions and have a conversation. The job is very easy. If you actually want to challenge the assumption that it takes 10 to 12 years for a new drug to come to market, which is, in my mind, crazy. It is crazy that it takes that long, and it's crazy that we have come to accept it. And the investor community just wants predictability, and if it takes 12 years and it's predictable, then they end up accommodating. We have to challenge deeply held assumptions. We are doing things now to eliminate animal testing. There's no need for animal testing. We have great computational modeling. It shaves off six years to a year. It's going to lower drug prices also, it lowers R&D costs. You can almost shave off that process by a year. And by the way, animal testing is not very good; 90 percent of drugs that pass animal testing don't pass in humans. So we got to use modern technology. We've got the AI tool now for all of our scientific reviewers. The pilot was amazing, and after the reviewers used it and said, "Wow, gosh, it's doing in seconds what would take me days." I said, "We want it agency-wide for all reviewers by June 30," and I'm happy to report that we delivered ahead of schedule and under budget. We're going to keep going phase one trials. Why are they going to China and Australia? We should be more competitive. We can set up protection of strategies, but ultimately we have to be more competitive on those applications. Why do we have phases done in separate, giant applications? You don't go to college after you apply and then apply again for your sophomore year with 100,000-page application. That's a real number, by the way, from the size of FDA applications, and then apply again for your junior year and apply again for your senior year. I mean, we can use new technology to run continuous trials and have the regulators look at endpoints in the cloud. We've got to try new things. We have our National Priority Review Program to get decisions out in weeks. We have, for example, a New England journal article just came out. We were talking about this for childhood deafness, a congenital form of childhood deafness. A New England journal study came out, 12 kids. You can't do a giant randomized trial, okay, we got to be real and have regulatory flexibility. It was about 12 kids, and three of them had a complete cure. I mean, they got hearing to normal, and then another seven or so got an improvement. I mean, that's amazing. And so we call that company. We're not in a receive only mode. You know, we're not going to be a stingy librarian as a regulator. We reach out to the company and we issued them a voucher immediately. Within hours, we were on this to get them a voucher to get a review within weeks. Okay, I want to see kids have their hearing back, and so we're going into the pipeline. I will go directly to the reviewers and ask them, "Are you seeing anything in the pipeline in animal studies, in phase two trials that look amazing?" Game changers, and if so, we're going to partner with that company and yet keep our review impeccably independent.

Esther Krofah 19:04

What has the response been to this plan? Are you getting excitement? Obviously, we had some applause around the room for that. What has the response been from the community? And how are we involving stakeholders? How can organizations and companies or even patient advocates reach out and say, "Yes, this is a disease condition that my child or my family member is struggling with." What's in the pipeline? How do we go through this process, really adhering to what you laid out as meeting public health needs?

Marty Makary 19:32

Well, I think Dr. Oz, and I will tell you, there's nothing like being at the bedside and proximate and listening to patients. Take, for example, the conditions that parents struggle with with their children. We can do trials in a 10-year randomized control study of red dye number 40. But you know what? You can also listen to parents when they say the child was on dyes. Like most kids consuming a lot of these petroleum-based food dyes, we eliminated that, the child's behavior dramatically improved. A year or two later, they got back into them because it's hard to police, and then the child's behavior regressed back. That is data, it's not a randomized trial and it's not conclusive, but you we can listen to patients and families and we can learn. Those are data points.

Esther Krofah 20:27

I should ask you about the leadership at FDA. Obviously, it's been in the news, and I'm sure many in the audience are interested to hear your perspective as well. How are you feeling about the leadership structure at FDA? You've had some shifts, obviously, with the recent announcement with the CDER director. What should we anticipate as a community in terms of each of those different divisions?

Marty Makary 20:52

Yeah, so we got rid of the fiefdom culture that was there before I came, the six major centers at the FDA. We have 16,000 employees. We regulate 20 percent of the US economy. We've got offices in 50 countries. It's a large organization. And the centers were running their own secret governments. The commissioners were sort of put out to pasture, you know, kind of like, well, we do what we want. We'll fill you in, and you can take some credit. So we broke that up. So we've got a teamwork culture, and we've got a great teamwork culture, teams working on everything. We're going to be announcing a bunch of new drug reforms in the next three months. These are reforms that a giant team has worked on. So we're going to continue that teamwork culture. And the FDA is strong. I want everybody to know the FDA is going to meet all of its targets with the user fee deadlines, we're going to meet all of our funding goals, and the FDA has been strong. The trains are running on time. They're running, hopefully faster now that we are going to cut the idle time, not cutting corners on safety, we're cutting the idle time in the review. We're using AI, we're modernizing, we're eliminating red tape, we're trying to deliver more cures and meaningful treatments to the American public, that's our number one goal, and healthy food for children and the FDA is going to continue to be strong, excellent.

Esther Krofah 22:11

Well, this is a question that's relevant for both of you. We are in the middle of a government shutdown, so really appreciate you being here with us, and it's also an incredibly busy time. How are you both experiencing that within your agencies? Maybe Dr. Oz, you can respond to that. How is that shutdown impacting CMS?

Mehmet Oz 22:28

We actually copied the FDA, and I just want to echo what Marty said about the agency. He has been a superstar as a colleague, and one thing that we focused on a lot at Health and Human Services, that Secretary Kennedy highlights continuously, is breaking down walls, because when we have artificial barriers that hinder our ability to regulate effectively, Marty will make a decision that I don't know about, I can't act on it for that reason, and you suffer. And there are many things we're doing, like the biosimilar announcement that Marty did again at the FDA, but it frees up some other ideas we had about innovation in general. But to specifically answer you, the FDA, because of their user fee structure, had the ability to keep some of their employees. It turns out, CMS also has user fees. Researchers have to pay for the data that we collect through Medicare and other sources. And so we had stockpiled a little bit of money, and although in the first month of the shutdown, we didn't use that, we realized that there were opportunities, and went through the traps. Starting two weeks ago, we were able to bring back the 50 percent of CMS employees who had been furloughed. That's important, because so much of what we have to do like taking the one big, beautiful act, you know, working families, tax cut legislation, and putting that to work. You need people. And if you want to find a solution to improve the Affordable Care Act, you need people like actuaries, insurance experts. It doesn't just happen because we talk at a high level. You need people in the weeds. And I'm pleased to announce today that the $50 billion rural transformation fund, the competition amongst 50 states. The applications were due today, and all 50 states submitted, which is a coup, which a real coup for the governors. I'm also proud of my team for able to continue that process on time, because it was statutorily insisted upon that it happened today. We will give $50 billion away by the end of the year. And to put that in context, only about 7 percent of Medicaid money goes to rural America. That's about $19 billion a year. Call $20 billion dollars. Giving rural America $10 billion more a year for five years, a 50 percent increase, the amount of money they get is transformative and will allow us to right size the health-care system in all kinds of innovative ways. And many of those innovations will spill over to suburban and urban America as well. When we figure out better ways for big hospitals to adopt smaller institutions to use telemedicine more effectively to improve working conditions, so that you can recruit more people in the health-care space or train more nurses, all these spill over to help the entire health-care system.

Esther Krofah 25:14

Thank you so much. That's really a tremendous opportunity for states, obviously, for those who are in geographically diverse parts of the country. Thank you for referencing our report as well. I've talked about it at nauseum at this summit, which is we released a new report on the Future of US Biomedical Research and Innovation. We talk about US competitiveness relative to the rest of the world. And what we talk

about there is like, how can agencies work together? There's so much data at FDA, there's so much data at CMS, there's an opportunity for us to use that data to generate insights and hopefully have interventions that actually can improve health. So as you think about your two agencies being here together, you collaborate in such a significant way. Are there opportunities for you to work even closely together? Where you have your legislative mandate?

Marty Makary 25:59

I will just say that that's the best part of the job. So we have a massive overhaul of big data. We should be looking at drugs immediately upon approval, immediately. We shouldn't be discovering five years later that Vioxx may have killed 38,000 Americans, or 15 years later that OxyContin may have killed hundreds of thousands of Americans. What are we doing? We should with technology today, we should have eyes on a drug to look at safety and efficacy immediately in big data and monitor signals. So we're getting new datasets in, and they're going to be useful for CMS and FDA, and so this is where the collaboration is fun. When we announced Leucovorin with a new indication for some types of autism, that was something that we talked about. We did it rapidly. Like I said, we don't mess around. We like to get things done. They've been talking about banning one food dye for 35 years, and we came in, we initiated removal of all nine petroleum-based food dyes within weeks. So we like to get things done. And with Leucovorin, within weeks, we had that literature summarized. We made it available to doctors who are treating patients with autism who find it helpful. So we like to get things done. We made that announcement label change. They immediately announced at CMS that they're going to pay for it. And so these are the areas where we can actually have a huge impact. We are now talking about how drugs and devices that come out of FDA, where CMS has to decide whether or not they're going to cover it. There's another long process. Well, we just did an in-depth scientific review. Can we help inform their review more efficiently? So this is the fun part of the job.

Mehmet Oz 27:45

Esther, I want to, again, applaud you for the reports. One thing about Mike is, in the team that you have Esther, is that you do your homework. And I was looking through it just very briefly, and I noticed one thing that I would add, which is hard to ever add something to Mike Milken and to this wonderful organization, but Marty and I have been working together because you asked about collaboration on important things like when they approve it. How do we make sure there's products, marketing surveillance, as he has outlined, that's true for devices as well. Those of you in the device space right now that's sort of fractured, and Marty's been very loud about this and actually pushing CMS appropriately so we can make it a seamless process, as it is with pharmaceuticals. We have a major national security crisis in America in that we don't actually make any of the raw materials for the medications that our country runs on, and these are medications that are not the expensive branded products. They're the basic routine medications we use for antibiotics for infections, the tools we use for metabolic syndrome management, cardiovascular management. Hospitals are very dependent on these and folks who have critical illnesses as well, and we have got to onshore products. That will happen, because the FDA is louder about some of the things it can do, like highlighting risks of importing products from other parts of the world. It's also going to happen because CMS works through funding mechanisms to make it worth it for people to start

developing products here. I don't want to get into all the details, because much of this is still ongoing. It is fast paced, but if you're looking for opportunities, that's what I would look at, for sure, is what can we do to make available in America key starter materials, APIs, and ultimately, an obviously finished product as well, in ways that are safe for the American people. And one good example of how we will incentivize this is TrumpRx. How many of you know about TrumpRx? It looks like about 20 percent of the audience. The TrumpRx is a place where you'll be able to go for any medication you're on and see the least expensive place and where you can buy it. And we're not going to sell the products. It's a government-owned entity. We'll send you to the companies who are putting their prices up, it'll often be the manufacturer. And if that manufacturer is a generic drug company, and they're made in the USA, we're going to market that it's made in the USA. So you know, it's a product that probably has a lower complication rate in terms of its processing and producing, etc., less likelihood that fraud, fraudulent fellows got involved in it. And I just want you to know, these are the kinds of opportunities that exist out there that you'll be seeing—and TrumpRx will launch this calendar year and will be functional by early next year.

Esther Krofah 30:11

We just have one minute left as we wrap up, I did want to ask you maybe one substantive question and then a quick wrap up, which is around clinical trials. That's been an area that we've been focused on at the Institute at Faster Cures for the last four years, since the pandemic, because it was just absolutely abysmal, our infrastructure in this country to respond during the pandemic. How do you think about clinical trials? Dr. Makary, certainly, we saw that we have sites in East Coast, West Coast, but the middle of the country really did not have clinical trial sites. How are you thinking about that?

Marty Makary 31:05

It's a major disparity in the United States. And if you look at the success of Operation Warp Speed, you have to ask, why can't we replicate that if somebody has a potential cure for a type of cancer? And so later today, we're going to be announcing the next round of products that will be the recipients of our national priority review voucher program. If a product is in line with the president's national priorities that is moving manufacturing to the United States as a national security issue, making drugs affordable in line with what Dr. Oz is leading with most favored nation status pricing, and meeting an unmet public health need, or our focus on medications that reduce downstream health-care utilization. If there's a medication that reduces the number of dialysis sessions you need, or the number of insulin shots you need, in my mind, that's a national priority. We can't keep going down this road of just throwing good money after bad into health care. Politicians talk about different ways to finance our broken health-care system. In this administration, we are interested in talking about, how do we fix our nation's health-care system? And that means addressing the health of the population in health-care utilization, and that's part of the work with pricing. We are not interested in 1 or 2 percent reductions in drug prices. We're interested in massive reductions, like the announcement that Dr. Oz made a couple weeks ago from the Oval Office taking down the price of a medication from $243 down to 10 bucks. That's the kind of reform I think we're really focused on.

Esther Krofah 32:43

Excellent All right, what's your takeaway? Dr. Oz, what do you have as a takeaway for this audience? What should they walk away with?

Mehmet Oz 32:50

We are open for business. Come work with us. You know, either call us if you've got good ideas. But more importantly, send your best, your brightest, your youngest. Have them come work with us. We've got lots of opportunities to make America a healthier nation, and this, I do believe, is a generational opportunity to do that.

Esther Krofah 33:08

Dr. Makary, any final thoughts?

Marty Makary 33:10

Thank you, Esther. It's great to be here, and thank you for having us. Our goals are very simple, more cures and meaningful treatments for the American public, increased affordability and healthier food for children. And let's be honest, we have to rebuild public trust. Coming out of the pandemic, public trust got cratered from 71 percent of the public. This is a JAMA study, 71 percent of the public trusting us as doctors and hospitals in 2019. Now it's at 40 percent, that's a 31-point drop. We have got to rebuild public trust, and we're going to do that by doing common sense things, cutting red tape, and by showing humility. If we don't know the answer to something, our answer should be we don't know, and that's the answer we're going to give people.

Esther Krofah 33:59

Well, thank you both for your incredible leadership on behalf of this country. Your success is the success of the rest of the world. Thank you so much.