Pfizer's CEO Jeffrey Kindler on Keeping Americans Healthy and America Competitive

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Here is a pragmatic way to think about health care "costs" and the promise that lies ahead if we do things right. Just spending less won't fix our problem. Changing who pays won't fix it. Cutting waste alone won't fix it. Rather, we need to change what we buy. First, we must invest in prevention and wellness to reverse the burden of illness and disease. Second, it's time to provide quality, affordable health care for all Americans. Lack of coverage imposes a huge economic cost, and not just in the tens of billions of dollars in unpaid medical services. The real cost is far greater and hurts our competitive status. Four elements make sense as a starting point: Choice of doctors and plans: Americans value this one. Core health care benefit: We should make the vital treatments available to everyone. Preventive Care: We spend 93 cents of every health dollar on treating illness --- and 7cents on preventing it. Electronic records: Institute of Medicine data suggest that between 50,000 and 100,000 deaths each year because we use paper records. One thing needed badly in the year ahead is a partnership where industry, government, nonprofits, and academics don't mask our differences, but explore them.

Vernon Jordan

When Jeff Kindler and his wife Sharon came to our home for dinner on Martha's Vineyard, it was clear to me that Jeff was destined to do big things in Corporate America. He was extremely bright, talented, experienced, attentive, and eloquent and he had a very healthy appetite. Jeff and I have been friends since. His response to my invitation to address the Economic Club of Washington was instantly positive, in part due to our great friendship, but more importantly, Jeff understood the importance of the CEO of the world's largest research-based pharmaceutical company and largest private biomedical research organization. He understood the importance of the CEO of this organization speaking to the nation's capital on issues crucial to the health and welfare of our democracy.

Jeff is no stranger to Washington. He served as law clerk to Judge David Bazelon of the U.S. Court of Appeals of the D.C. Circuit and as law clerk to U.S. Supreme Court Justice William J. Brennan, Jr. He then joined the law firm of Williams and Connelly, where he became a partner, moved to General Electric as Vice President of Litigation and Legal Policy, and then on to McDonald's as Executive Vice President and General Counsel. Before he officially started as General Counsel at McDonald's, he had to earn his stripes at a McDonald's on U.S. 95 in Connecticut. While Jeff tried his best, he simply couldn't get the hang of the Big Mac, so he retired to the General Counsel's office for the rest of his time there. Friends say that, brilliant as Jeff is, watching him at a McDonald's was

sheer comedy. Given his weight increase from McDonald's calories, Jeff happily signed on as Vice Chairman and General Counsel of Pfizer and, just nine months ago, he was named Chief Executive Officer of Pfizer.

A *summa cum laude* graduate of Tufts University, a *magna cum laude* graduate of Harvard Law School and editor of the *Harvard Law Review*, Jeff Kindler has had a meteoric rise in corporate America. He is a good man with a good heart, and I am proud to present my friend Jeff Kindler to the Economic Club of Washington.

Jeffrey Kindler

Last month, I was reading a *Barron's* article about which companies have the best prospects for discovering a medicine that can reverse Alzheimer's. This being *Barron's*, the focus was, of course, on stock prices. But I found myself focusing on someone they interviewed: a man named James Smith. A year ago Mr. Smith had begun forgetting things. Couldn't keep track of time. Couldn't do more than one *thing* at a time. The diagnosis confirmed what he and his wife dreaded. Early Alzheimer's. He's 47. He and his wife had seen relatives die of Alzheimer's. "Neither of us," he said, "has any illusions about where this goes."

It was a haunting story — of an intelligent man, fully aware of how, each day, his brain deteriorates. He's powerless to do anything about this disease that will affect one in three people in this room who reach the age of 65. I'm the head of the largest drug company in the world. But I'm equally powerless to help Mr. Smith.

So while I'm here to talk about health care and competitiveness, don't think I'm forgetting for an instant what's also at stake in what my company does. The fight to stay healthy and alive. And, yet, staying competitive is <u>also</u> a fight to stay healthy and alive. Paying too much for *health care* puts our *economy* at risk. So I appreciate the chance to talk to you about the ways they intersect.

Today, I'll outline what I hope is a pragmatic way to think about the problem of what people call health care "costs" … outline two changes I believe we must make … and the promise I see ahead if we do things right.

I do this acutely aware that there are at least a hundred people in this room who've thought deeply about this issue for decades and are far more expert than me. I feel a little like the man who drowned in the great Johnstown Flood. When he got to Heaven, he asked St. Peter if people there might like to hear about what he went through in the flood. St. Peter said, "Well – okay. But don't talk long. You'll have Noah in the audience."

It's daunting to take on this complex problem – one that has eluded solutions for years. But I'm an optimist. Everyone now understands that this is a serious crisis. As a result, people are getting serious about trying to find practical solutions that transcend politics and ideologies. That's why we find rather unusual pairings of people and organizations

dedicated to addressing the problem — The Business Roundtable and the AFL-CIO; WalMart and Andy Stern. Hillary Clinton and Newt Gingrich

To succeed, we must all work together — across party lines, across the public/private divide. Health care providers like the biopharmaceutical industry must play a constructive role. Today, people see us as a major part of the problem. We must be part of the solution.

Biopharmaceuticals is an innovative industry. But, in order to help solve the health care crisis, our industry needs to acknowledge some big mistakes. Many companies – not all, and not without internal dissent — resisted user fees in the 80's and early '90s. Fought the idea that we should make AIDS drugs available in Africa for those who couldn't afford them. Opposed Medicare drug benefits for far too long.

Today, our industry's sales and marketing practices still bother some of our customers – patients, physicians, and payers. We need to take a hard look at those practices. Most fundamentally, we need to move from an industry that has sometimes seemed at war with its environment and with some of its customers – including the governments who often pay the bills – to an industry that anticipates, understands, and responds to *all* of our customers.

One test of the changes in our industry is happening even as we speak. This week, the Senate is debating an enormously important bill introduced by Senators Kennedy and Enzi. It requires candor about clinical trials....provides added resources for safety monitoring and new authority for risk management plans … and it creates a new voluntary user fee to cover FDA costs for reviewing our TV ads. All good.

Do I agree with every aspect of the legislation? No. Should we support the Senate's passage of this bill? Absolutely. I also believe that the FDA needs far more resources than it gets. Right now, FDA funds 60% of its work reviewing new drugs with user fees from our industry. But one side effect seems to be that people think we not only fund the work – we influence it. We don't. But Congress should correct the balance. It should vastly increase its funding of the FDA so that the agency can do its job – ensuring that the public gets a steady flow of safe and effective new medications.

But safety – while critically important — is indirectly related to our health care crisis. Let's take the major issue head on. Here's how I hear it from CEOs. "If we could only get these health care costs off our back, we could really compete." They correctly link two of America's main concerns: keeping Americans healthy – and keeping America competitive. There really can't be any dispute that health care costs in this country are tremendously high. About 16% of GDP – almost $2 trillion dollars, heading toward a seemingly unsustainable 20% of GDP in the next decade. And we spend proportionately more on health care than many other developed countries. Naturally, that makes American companies consider moving elsewhere.

Ironically, two of the factors driving the growth in health care costs are actually good things: effective treatments we couldn't have imagined a few years ago – and growing demand from a population living longer than ever. But if the causes are good, the effect on cost is not. It clearly costs a lot for the economy as a whole — and far too much for those without the resources to pay.

And the problem is even worse than that. For all that we spend, our system is grossly inefficient. Consider the enormous regional *variation* in costs across the country. Take two average Medicare patients. One's from Minneapolis. Average cost for a year's care: about $5,200. In Miami? A little over $11,000.

Why this huge difference? The data show that the price of individual things — an operation, a hospital stay, and prescription drugs — varies very little. It's how *many* of those things doctors prescribe that accounts for the difference. For whatever reason, Medicare patients get a lot *more* care in Miami than Minneapolis.

But here's what's really disturbing. The Miami patients – as one researcher put it – "do not have better health outcomes." They don't even have more "satisfaction with care." Its $6,000 more and no better outcomes – and that's for those who *have* access to health care!

There is also wild variation in what an individual insurance policy costs – a 20-something single in New York City may pay five or ten times the amount for health insurance coverage than they would pay if they lived a few miles away in Connecticut. Even more troubling, studies show that in the same community we have enormous disparities in health care outcomes for no other reason than the color of a patient's skin.

So what do we do about our rising and inefficient spending on health care? Let's look at three possible options:

- **Spend less – and suffer more illness.** Not a lot of popular support for that.

- A second, more popular way to "get health care costs off our backs" is this: **have someone else pay.**

This idea – naturally — seems very attractive. Employees want employers to pay for health insurance. Employers would like their employees to pay more. Many want government to pay. But, of course, shifting the costs around doesn't really solve anything. If employees pay, the public pays. If employers pay, they raise prices – and the public pays. If the government pays, taxpayers – in other words, the public -- pays.

- **Now the third way. Cut health care costs by reducing profiteering and waste**.

That is *very* popular. Can we be more efficient? Squeeze more savings out of the costs that an insurer sees? We certainly can. Anyone who walks into a clinic and sees medical records in folders stuffed into filing cabinets knows that.

What about reducing profits – for example, on drug prices? Everyone here knows that the pharmaceutical business is a risky one. It takes 1 out of 10,000 compounds to get a marketable drug. Those who invest in companies like Pfizer expect a reasonable return on the few drugs that turn out to be profitable. But why are drug prices so much higher here than in other countries? Partly because other countries impose price controls. That means Americans subsidize the research and innovation that helps the rest of the world. That's unfair. It's an important trade issue. We need to address it.

But even if we froze the price of drugs today, that wouldn't solve the problem of escalating health costs. Most people think medicine makes up half of those costs or more. In fact, it's 10% or 15%. Right now health care costs are going up about 7 cents on the dollar each year. Freezing our drug prices would cut that growth from 7% to 6.5%. You'd solve almost nothing – and jeopardize an industry that provides over 3 million jobs.

So we come back to the basic question – how do we reduce costs and ensure that we spend our money efficiently?

To me there's a fourth way. But it means doing a little homework. Because you can't discuss cost until you figure out what you want to buy. That's true of a refrigerator, college tuition – and health care. What is it we want to buy?

One answer is: better health. That's an abstraction. It's like saying "I want a better refrigerator." What does "better" mean? You have to weigh all the benefits – against all the costs. You look at the EnergySaver sticker on the fridge and say "*That's* what electricity costs? Let's go home."

But what people do at Home Depot, they ignore health – even people who know better. That includes those in the three groups to whom Americans have delegated the job of purchasing health care – insurers, employers, and the government. So, let's look at cost from the perspective of those three groups.

First, **through the lens of private insurers.** Let's say they're looking at an Alzheimer's patient like James Smith. If that patient is not on drug therapy for that disease, what's the overall cost? A study published in 2002 estimated that it's about $12,000 a year. A dollar breaks down this way: Hospital care – about 59 cents; skilled nursing and home health – another 25 cents; doctor's visits – about 9 cents; and medicine for other conditions – about 3 cents

Now this study shows that for patients on drug therapy for their condition – the cost breakdown changes dramatically. Drugs go up, obviously -- from 3 to 15 cents. But hospital care goes down from 59 to about f50 cents. Skilled nursing/home health goes down from 25 cents to about 11 cents. Overall there's a reduction of about 33% -- down to $8,000 dollars a year. Insurers can't always take those kinds of savings into account. The effects may not benefit them. The drug costs happen today. But by the time we realize any savings, the patient may be on another insurance plan or on Medicare.

Where is the incentive for an insurance company to invest in care today that will reduce costs for another insurance company or the Medicare system? Insurers do compete on the quality of care they offer. Some offer great programs. But this kind of quality is tough to measure and tough to sell. There's not much advantage for them to focus on it, given the dynamics of the market.

Let's try another lens: Corporations. Corporations focus on insurance, too. Auto manufacturers divide medical premiums by the number of cars. That's why General Motors says health care costs $1,500 a car. If you were expecting me to dispute that, I don't. The cost is actually higher than that. Insurance premiums may add up to that amount. But medical costs make up less than half of what employee illness costs a company.

Here's what one study suggests a typical sick employee costs a company when you add up absenteeism, disability, and productivity losses from "pres-en-*tee*-ism" (that is, people who show up but are too sick to drive a forklift, or too distracted to finish a report.) Depression, about $19,000 per year; back and neck pain, almost $10,000; arthritis, a little over $9,000; asthma, almost $8,000; and smoking, about $3,800. Why do corporate CEOs tolerate those additional costs? Like insurers, they are prisoners of the situation. You can't order a sick employee to come to work. You can stop insuring them – as corporations all over America have done. And, of course, you can move jobs overseas.

But all of that is obviously undesirable. Employer-financed health care, with its roots in the wage controls of World War II, may be imperfect. But, it is still the system by which most working Americans get health care coverage.

Companies that stop providing insurance are likely to become not more competitive – but less. Many employees will go without coverage. Uninsured employees risk more illness. More disability. More absenteeism. That drags the employees and their companies down. It also drags down the economy.

Just spending less won't fix our problem. Changing who pays won't fix it. Although we must reduce waste, cutting waste alone won't fix it. The bottom line is this: We pay a lot to cover only part of our problem. So our target cannot just be health care premiums. When we look not through the narrow lens but the wide-angle, it's clear. Our target must be illness.

That suggests a fourth way. I didn't invent it. I just believe it's the right way. We need to change what we buy. To see how we might do that, let's look through the lens of government.

What role can government play in helping us do what we consumers would do with that refrigerator? How can it help us figure out what illness really costs us … how much our system saves us … how much it could save if it worked better … and help create a system that works for everyone? It's not as if we have no government health system in place. In fact, government spending – Medicare, Medicaid, VA and other programs –

makes up about half of our total spending on health care. Private insurance is only about a third.

So clearly we can ask more of our government health system. What should we ask? You need to be cautious about answers from someone who until five years ago was thinking every day about how much steak goes into a Chipotle burrito. A lot, actually.

I understand that the market doesn't solve everything. In fact, I strongly believe that the government can play a critical role in two areas. Whatever else we do, we must do these two things.

First, we must take the long view. We must invest in prevention and wellness to reverse the burden of illness and disease. I can see some of you rolling your eyes. You've heard this before. But we are one of the most obese nations in the world. We have one of the highest rates of traffic accidents in the world – with many accidents avoidable by something as simple as buckling a seat belt. Too many of us still smoke. We have over 30,000 gun deaths a year – half of them suicides. These self-inflicted ills drive up our healthcare costs. **So which is the competitive disadvantage – that we pay so much for healthcare, or that we need so much more in the first place?**

Here's a way of addressing this. Less than half of American companies and nonprofits offer any wellness programs. Pfizer has one. It works well. Why don't others do it? As with insurers, it partly comes down to timing. Turnover in companies is so rapid that by the time wellness programs pay off the workers might be working someplace else – or be on Medicare. Because the Medicare system would eventually benefit from healthier enrollees, some researchers propose a federal incentive to encourage wellness. For example, I've seen an intriguing idea from John Podesta's group – The Center for American Progress - that proposes a national trust to encourage and fund wellness programs. It's worth exploring.

Second. Let's deal with a **problem that endangers the health of Americans and the health of our economy: the 46 million Americans with no health insurance.** It's a scandal. An outrage. In addition, it's a huge economic cost. And I don't just mean the tens of billions of dollars in unpaid medical services. The real cost is far greater. How do you put a value on the 18,000 needless deaths a year researchers attribute to lack of insurance?

You saw one of them recently, here in Washington. A homeless boy in Prince Georges County had an abscessed tooth. Something a dentist could have treated in an hour for $80. Why didn't Medicaid take care of it? Because his mother's Medicaid insurance had lapsed. By the time she found a dentist that would accept her son, the infection had spread to his brain. And so 12-year-old Deamonte Driver died.

Debate about the cost of health insurance does not include enough discussion about the entire cost to America of all the Deamonte Drivers -- an uninsured population now equaling the population of 26 states. There will be great social and economic benefits to

covering the uninsured. But without even accounting for the harder-to-measure benefits, the Urban Institute concludes this: we could insure them all for "an increase of 3% to 6% in health care spending." That's less than the annual inflation in spending for the system we have now. Less than 1% of GDP.

So I believe it's time to provide quality, affordable health care for all Americans. What would a successful plan involve? Again, I am mindful of the fact that many of the people in this room have invested their careers in this issue. Here are four elements that make sense to me as a starting point:

- *Choice of doctors and plans: Americans want to preserve individual freedoms. They value this one.*

- *Core health care benefit: There's a difference between a tummy-tuck and a mammogram. We should make the vital treatments available to everyone.*

- *Preventive Care: We spend 93 cents of every health dollar on treating illness --- and 7 cents on preventing it. That's like putting all our energies into treating bullet wounds of our police – and none in bullet-proof vests.*

- *Electronic records: There's Institute of Medicine data suggesting between 50,000 and 100,000 deaths each year because we use paper records. Inexcusable.*

These are principles totally consistent with views I hear across the political spectrum. These elements aren't the only ones that a successful plan would involve. And I don't want leave the impression that any plan is fine with me. I believe we must have a partnership between government, the private sector, labor, and nonprofits. That includes patient and physician groups. All the stakeholders – governments, businesses, individuals – have *skin* in the game. Each must maintain an active voice in determining the *rules* of the game. This will help ensure that long-range benefits are not crowded out of the debate by short-term cost constraints.

Do you want good, fast, or cheap? So far we've only been able to pick two. I believe we can become efficient enough to have all three. In the end, saying we spend too much is fundamentally a value judgment. If we spent efficiently Americans might decide to buy – no, invest — even more in reducing the burden of illness and disease.

Real solutions will take a lot of negotiation. A lot of debate. A lot of compromise. At Pfizer, we intend to earn a seat at the table. Once there, we will work to be part of the solution. I volunteer to talk to anybody. I want to contribute to turning what Andy Stern calls the "culture of failure" in our health care debate into a "culture of success."

There's nothing revolutionary about the ideas – efficiency, wellness, insurance for all – that I've talked about today. Everyone has been part of the never ending discussion about tradeoffs between access, cost and quality that we've had for 50 years.

But now the problem has become so serious that everyone recognizes we must solve it. And I do not share the skepticism about our ability to achieve solutions in Washington. The public can caricature politicians. I'm grateful that I lived here long enough to know they are – generally — people with nuanced views, a passion for issues, and for doing the right thing. The public is too quick to caricature corporations, too.

But a while back I was touring one of our labs. I started talking with a researcher. He was in his thirties. Working on an Alzheimer's drug. I asked if he thought we'd see a cure in his lifetime. He said probably not. I said, "What keeps you going?" He said, "I'm building on what people did before me. And people after me will build on what I did."

This is what makes my business exciting. That scientist may not get the chance to make a great discovery – most people don't. People *like* him will. I know that because I see it happening every day. I see a million and a half people already using a pill that helps smokers who've never been able to quit — throw away cigarettes and never start again.

I see people come in to show me the latest batch of studies on a way to help AIDS patients who've become resistant to everything on the market. I hear people explaining to me what "monoclonal antibodies" are and suddenly it's not an arcane term but a way to eliminate the cancer of people I know. But what good is it to solve these problems of science, if we can't work as partners to solve the problems of policy?

So, if there's one thing I hope to see in the year ahead, it's this: a partnership where industry, government, nonprofits, and academics don't mask our differences but explore them. Where we don't dig in our heels but roll up our sleeves. Where we use common sense to find common ground – and take the bold steps we really need.

The threats to prosperity and health are *threats* to all of us. We can beat them back, get them off our backs – by making sure the solutions *involve* all of us. And by remembering there are millions of Americans like a 47-year old man with Alzheimer's named James Smith who are running out of time.

Thank you.

Question and Answer

Vernon Jordan: First question, Jeff. Is a part of escalating health care costs due to an overabundance of care on the part of M.D.s and advertising on the part of Big Pharmacy?

Jeff Kindler: I'm not sure what an overabundance of care would be. It is true, the medical community will tell you, that a lot of tests and treatments and other practices and procedures are engaged in as a result of what they would call defensive medicine, concern about medical malpractice liability, and there is probably a substantial amount of activity that has been increased by that. That is a legitimate concern, and when you talk to doctors, they will tell you that sometimes they give tests that they would not have otherwise given. Regarding drug advertising, an obviously controversial subject, there is

evidence that it will make people aware of illness that they didn't otherwise know that they might have to consider. They go into doctors' offices, and they often find out they have other conditions that they did not know about. Now, obviously our industry has been subject to some criticism and I think, quite frankly, legitimately, for the nature of some of our ads and we've been working very hard to change that.

We recently introduced a very unusual ad for Celebrex. It is 2 ½ minutes long and unlike any other drug ad, it starts out talking about risks. It doesn't get to benefits until late in the commercial, which is the opposite of how it has historically been done. But I don't think there is a lot of evidence to suggest that drug ads drive up unnecessary usage. At the end of the day, we do need to rely on the doctors to make those judgments. We, as patients, need to do that, and not many doctors are going to make prescriptions based on the fact that someone saw a television ad, at least I hope not. I hope my doctor wouldn't.

Vernon Jordan: What are the new innovations for future medicine likely to be? Where are the breakthroughs for medicine going to come from in the future?

Jeff Kindler: Lots of people can talk about those possibilities. Lots of interesting things are going on, so I'll just pick a couple. We are now at the point where HIV/AIDS has become a treatable/chronic condition as opposed to the death sentence that it was 20 years ago. Many of us in this room are going to live to see many forms of cancer achieve the same status. We are making tremendous, "we" meaning biomedical research in general, progress against cancer, much better understanding of it, and I think we are going to see a lot of breakthroughs in that area, and there are already many coming out.

The other thing that is going to happen in medicine in general is, which I'm sure many of you have heard of, called personalized medicine. We're getting better at figuring out what class of patients, what subcategory of patients, would best benefit from a particular drug either because it would be more effective with them or because it would be safer and not have the adverse effects it might have on a broader population. This is partly because of the understanding of the genome. We just are about, I hope, to get FDA approval of a new AIDS medicine that comes with an assay that the patient takes to determine whether he or she is the right type of patient for that drug, because it doesn't work on some and it works for others. We are going to see a lot more innovations along those lines.

Vernon Jordan: If we want an incentive to invest in preventive care and wellness, wouldn't we be better off with long-term contracts between providers and consumers?

Jeff Kindler: The short answer to that is yes. The more that the provider, whether it is government or employer or insurance provider, is invested in the patient's long-term well-being, the more they are likely to make investments in prevention and wellness. Our company, and there are a lot of other companies that are doing this as well, is making significant investments in the prevention and wellness of our employees, in part because we believe that, while we will have a lot of turnover, most of our employees will be with us for a very long time and it is in our interest to do that. So there is a lot to that point.

Vernon Jordan: Is Viagra and its competing drugs a necessity or a tummy tuck? How big are these drugs in dollars?

Jeff Kindler: Erectile dysfunction is a real disease, and there are people who suffer from it, and it has a lot of co-morbidities that go along with it. In fact, going back to my comments about television commercials, a lot of people who have gone in to see the doctor for ED have discovered that they have many of these co-morbidities involving cardiovascular risk and the like. So there are many, many people for whom it is essential. Having said that, I can't deny that it is abused and that there are people who abuse it and a lot of that, I have to say, is driven by counterfeits. Viagra is by far the most counterfeited drug in the world. We estimate that something like 60% to 70% of the sales of Viagra in places like China are not made by us and may be being used for recreational and other purposes because no doctor is involved in prescribing them. So it clearly can be abused, and it is clearly people it isn't for. In terms of the sales of these drugs, they are about a couple billion dollars, if I recall correctly. I am looking at my friend. Am I in the ballpark? Two billion, yes. Thank you.

Vernon Jordan: Do you import any of the raw materials that you use in pharmaceutical manufacturing from China?

Jeff Kindler: We manufacture pharmaceuticals in China. We've had a plant there since the 50s. We manufacture all over the world, so we have supplies coming from all kinds of places, and we're doing more and more manufacturing in Asia. The short answer is yes.

Vernon Jordan: This is the last question, and Jeff, I have to ask you because somebody sent it up here, and I am trying to keep my job. Of the current presidential candidates, who seems best equipped to lead us to a cheaper, fairer, better healthcare system?

Jeff Kindler: Vernon Jordan for President.

Jeffrey B. Kindler

Jeff Kindler is Chairman and Chief Executive Officer of Pfizer, the world's largest research-based pharmaceutical company. Prior to his appointment as CEO and election to the Board of Directors in 2006, he was Vice Chairman and General Counsel, where he led Pfizer's worldwide legal, compliance, communications, government relations, corporate citizenship, policy development, and global security groups.

He joined Pfizer in 2002 as Executive Vice President and General Counsel and was named Vice Chairman in 2005, joining the company's four-person Executive Committee and assuming responsibility for Pfizer's Corporate Affairs Division.

Born in Florida and raised in New Jersey, Jeff Kindler earned his B.A. from Tufts University, *summa cum laude,* and his J.D. from Harvard Law School, *magna cum laude,* where he was an editor of the *Harvard Law Review*. He began his legal career as an attorney at the Federal Communications Commission, then served as law clerk to Judge

David L. Bazelon of the U.S. Court of Appeals of the D.C. Circuit and later as law clerk to U.S. Supreme Court Justice William J. Brennan, Jr.

Jeff Kindler joined the law firm of Williams & Connolly, became a Partner there, and then moved to General Electric as Vice President of Litigation and Legal Policy. He next joined McDonald's Corporation as Executive Vice President and General Counsel. He moved into line management at McDonald's as President of Partner Brands. He has been recognized for his leadership in the areas of *pro bono* legal services, diversity, and corporate social responsibility.

Jeff Kindler serves on the boards of trustees of Tufts University, the John F. Kennedy Center for the Performing Arts, Business Roundtable, Manhattan Theatre Club, the Council on Competitiveness, New York Philharmonic, the Partnership for New York City, The Business Council, and Ronald McDonald House Charities, as well as serving as the Chairman of the U.S. - Japan Business Council