

AMCHP 2008 ANNUAL CONFERENCE

WE ARE MAKING A DIFFERENCE:

Opening Plenary:

A Vision for a Compassionate and Affordable Health System

March 1st to 5th, 2008

MICHAEL FRASER: This morning's celebration brings me back to one of my pairs of grandparents' 50th anniversary party. We were down in some retirement community in Tampa near there, and our huge family came together to celebrate their 50 years of marriage. And we started making remarks and everyone started crying. It was just an emotional event. And my grandmother, who is now 96, said: Mike, why is everyone crying? This is supposed to be a party? So I think these are tears of joy and celebration for all the hard work that these individuals have done and the importance and real connection that this work has to our lives.

This is about us as families and individuals and people who work not nine to five, but 24/7, to make a difference.

Then as Monte Python would say: And now for something completely different. I have the real pleasure to introduce a wonderful speaker, a provocateur in the truest sense of the word, who is joining us today with the wonderful support of the National Conference of State Legislatures, and Martha King and her staff have been wonderful resources for us. Martha, if you don't mind saying hello. Martha is based in Denver. And represents all those state politicians across the country who, again, make a difference working day in and day out for all of us.

Governor Richard Lamm was the Governor, three-term Governor of the great state of Colorado, a wonderful place to live and visit from 1975 to 1987. But not only was he a politician, he is a prolific writer and a novelist and his most recent work, which I've read which is called *Brave New World of Healthcare*. I think it's important for us in public health to take an hour or a little piece of that hour this morning to think about healthcare and healthcare reform.

This is something that we're hearing all about this election year. And something that impacts our programs, whether we want to deal with it or not. How we pay for healthcare services, how we integrate primary care into our public health framework is a crucial, crucial issue for us.

Dr. Lamm's not going to come up here and tell us what we want to hear. And I think that's a wonderful opportunity for us to really think about these issues. We know the squeeze on state budgets is coming from the way we do healthcare. Definitely not the way we do public health, necessarily.

The declining economy and our eroding tax base, those factors need to be considered as we move forward and think about our work. The perfect storm, really, for the healthcare financing woes is brewing or has arrived. It's raining, there's wind and tornados and we need to do something. And what governor Lamm offers to us is a possible solution or set of steps we can take. And almost, more importantly, he's engaging us in the tough conversation, because this isn't easy, nor are the solutions.

Above all, I appreciate governor Lamm being with us this morning coming from Colorado and having patience to celebrate with us in this award ceremony this morning. I apologize for taking some of your time, but I think you can acknowledge just how important and significant this morning is for us. Thank you for being here with us. And I welcome you to AMCHP.

RICHARD LAMM: I'd like to thank you for your infectious enthusiasm. I thank the rest of you for your invitation, but more important, thank you for the incredibly important work you do.

So often unsung, but deeply appreciated by those that know that society rests on just, not everybody, but select individuals.

My children were seven and four when we moved into the governor's mansion. And that's a pretty heady experience for a young kid. And my wife Dottie would keep telling our son: Don't think of yourself as the governor's son. You're Scott Lamm, an individual, unique in itself, and so we were at the mall not too long afterwards and somebody introduced themselves to me and turned to Scott and said you must be the governor's son. And he said that's not what my mother tells me.

You know, public policy is like beauty. It's perhaps in the eye of the beholder, but let me tell you one of the things that just haunts me, and that's that healthcare has been growing all during my professional lifetime at two and a half times the rate of inflation.

And nothing can grow at two and a half times the rate of inflation forever. So our current medical practice patterns, our medical ethics, our personal expectations, our providers, our suppliers, everything out there has been sort of used to this incredible flow at two and a half times the rate of inflation.

It's been growing that way with a little cease in this in the mid 1990s. But I believe outside of war it's the biggest transfer of assets to one section to the other that sort of society has ever seen.

When I was just getting started on my professional, we spent, as a nation, six percent of our gross national product in education, six percent on defense and six percent on healthcare. Now 2004 it was six percent on education four percent on defense, 16 percent on healthcare.

Now, you know you can say we're still spending too much money in defense. I think we are. But the fact is that it's most of the new money of my generation has gone into healthcare and entitlement programs.

So in 1964, the average hourly worker had to work until mid-January to pay their healthcare costs. Mid-January. Today the average hourly worker has to work until mid-March. So healthcare is crowding out so many other things that we have to do to leave our children a decent life.

1965 we as a nation spent the same amount on healthcare as we did education. Today we spend -- 2000, but it's the same today, the same amount on healthcare as education, defense, prisons, farm subsidies, food stamps and foreign aid. It's simply crowding out all of the other things that we have to do with our budget. And government's funds now about 50 percent, a little over 50 percent. When you take it's not the normal figure you see, but when you take the fact that none of us pay taxes on that portion of our healthcare that is paid for by an employer, it's called tax expenditures. When you add that on to the other money we spend in healthcare, it really, I think, comes to be 55, 56 percent of healthcare is paid for by government.

So we've sort of so-called sort of half socialized healthcare. So here's my bottom line on healthcare and my thinking. That no nation can build a healthcare system a patient at a time. That no citizen can expect in this time of technological miracles all the healthcare that modern medicine can provide.

That no physician can practice their profession, assuming they're the unrestrained advocate of every patient. That no nation can expect and no nation can afford to give the Hippocratic oath a blank check.

I believe that not only is the Oregon health priorities system ethical, I would suggest to you it's unethical not to have that. Whoever distributes limited funds has an ethical duty to maximize the health and life that they can get from those funds.

So when you take this from a public policy viewpoint, the United States as you know denies more healthcare to more people than any developed country in the world.

I saw a bumper sticker the other day that says I've recently become a Christian Scientist. That was the only health plan I could afford. (Laughter) and I love this quote. If you disagree, that's wonderful. But at least we're debating some of the core questions. This was written a couple hundred years ago it says it's better to debate a question without settling it than settle a question without debating it.

And I'm afraid that's what we're doing on so many important issues, as we continue to expand the entitlements and the healthcare budget into lots of other things.

So here is sort of one lens that I think that we have to, that we should help -- it helps sort of get some of the problems that we face in perspective. I divide the health transaction into four different layers of what I call moral geography. The first being self-responsibility. The second being the doctor/patient relationship. But doctors do their magic by spending other people's money. So we have to look at the health plan and community, whoever distributes the insurance or the community funds and then, of course, the state or the nation.

Let me break them down one at a time. But what I would argue is that each -- it helps us to think about the fact that each floor on this house of healthcare has its own moral radius or moral geography.

For instance, the State or the nation. Let's start there. One of the things that every government has to do is decide how much government funding. No government funds healthcare entirely by the government money and no government relies only on market.

As I mentioned, we now are over 50 percent in the United States funded by government money. Well, Canada is only 70 percent government money. 30 percent of Canada is by co-pays or individual payors. So when you decide these issues from the government standpoint, let me start off by saying we have to run a nation of 50 Floridas, that's where we're headed.

We often think about it as retiring new baby boomers, but it's really something much more than that. Up in the left-hand corner is the regular population pyramid that was 1900, then to the right is 1970. Here come you baby boomers. And then the left bottom corner is 2000. And the baby boomers in the height of their careers.

And one up at the right is 2030. And this is the -- this pyramid has become a rectangle, and the implications of this I believe are absolutely staggering. First of all, it's good for us individually. We've added 30 years of life expectancy this last century. You mentioned your 96-year-old grandmother. My father, my 98-year-old father just died last year. But he shows up at a family function not too long ago, when he's 96. He had this T-shirt on. It said: When did my wild oats turn into shredded wheat?

So this is wonderful. Agatha Christie was married to her beloved husband Max. Max was an archeologist, 14 years younger than Agatha Christie. Agatha used to say all the time: It's wonderful being married to an archeologist. Each year you get older he gets more interested in you.

And this is happening all over the world, of course, that there's a drop in the birth rate and extension. And we have no idea where this is going to end up because we absolutely believe that we have identified or are close to the Methuselah gene that will in fact extend life even more than it is right now. And we've had this incredible drop in the birth rate.

Never have fertility rates fallen so fast, so low for so long in so many places so surprisingly.

So we've got this new dilemma. I would suggest to you that the new deal is demographically obsolete. That isn't a political statement. I come out of the democratic party. But you cannot support the programs that were started when I was graduated from high school. There were 13 and a half workers for every person retired. Now there's 3.3. We're heading for two and a half. And you simply can't support. So we had ourselves this dilemma. The most popular political programs in America are demographically

obsolete. They can't be sustained. We're going to have to make substantial changes to them.

So what do we -- here is the most terrifying public policy slide that I've ever seen. The green line up there is the projected revenue of the United States government before the Bush tax cuts, because they weren't made permanent. They were not included in the green line.

And this simply shows that by 2030 our current revenue and current taxes that we pay and complain about will only fund four, four of our existing federal programs.

Social Security, Medicare, Medicaid and other retirement. VA and other retirement related systems. So up in the blue, the yellow was the interest on the debt we're leaving our kids. Up in the blue is the national parks and the judiciary and the White House and the agricultural department, everything else that we need to do to, I think, have a decent society.

And one of the dilemmas I would really love to have you focus on in a minute is however gargantuan this is about questioning how do we solve the healthcare problem, that in

public policy we've got three related problems. We've got healthcare which we call Medicare, that the government before my time undertook three major roles. Medicare, retirement income. Social Security, long-term care called Medicaid. And, of course, there's a hydraulic relationship between these three.

Money you spend on one you don't have available to spend on another. And not only that, if that isn't enough, then you have to sort of solve all of these three as sort of an interconnected equation. We then also have to decide how much do we spend on these programs that are applicable to people my age and over, as opposed to other things that a society needs to do. Roads and schools and all those other things that we need to do.

So Yogi Berra says: I'm leaving the status quo as it is. It's not that easy. And we refuse to talk about it. Nobody likes to talk about taking on this whole question of entitlements.

So public policy has failed to provide either cost control or to provide access.

83 percent of American healthcare is paid for by some third-party payer, either private insurance or government pays.

So all of a sudden now we're told that we need to make the market work better in healthcare. Actually, I have a lot more respect for the market than I did when I entered the Colorado Legislature in 1967.

But you know we've looked at this and tried to make it work. We've tried to make the market work. But because there's such an asymmetry of information between a doctor and a patient, because we buy healthcare with 17 cent dollars, you can't make the market work unless you have real pain in your wallet.

And we don't have that in American healthcare, whether it's government or whether it's insurance doesn't make any difference, we're insulated from the impact.

And so much of healthcare's purchased by the frail elderly or the seriously ill. And it's hard to make them good shoppers.

So I believe that -- I'll skip that one, actually. I'm not. One of the yet issues that we haven't taken up, actually, is how do we fund the healthcare. There's a whole second level of healthcare issues. If we think -- if we had enough problems with the first one then we've got the second level of healthcare problems. Do you cover acupuncture, what do

you do with chiropractors, how do you fund it? And this chart, this shows, for instance, that the top left would be experience rating, where if you have a pre-existing conditions, you're being weighed down. The middle one would be community rating, which is what my generation thought was the great liberal reform, community rating. We're all charged the same thing. But of course that isn't progressive or even close to being progressive.

So what other nations have done and we haven't even started talking about, is coming up with some funding system that is a self-progressive and but we have this new issue called intergenerational equity. Intergenerational justice. That we are leaving our children such a staggering federal debt and unfunded liabilities. And so this is Baron Von Bismarck, the iron chancellor of Germany in 1883 started this whole social insurance systems where I pay for my parents in return for the implied promise of my children to support me in similar programs. And it was great.

No problems, ideological problems with it, it's just that in 2030 there will be twice as many elderly but only 18 percent more workers. And that just makes it as one, my friend said, we made a massive bet on the ability of our children to support the elderly. Then we forgot to have children.

So we have this kind of thing that I don't think really makes sense. The poorest people in America are elderly widows. And the richest people in America are: Elderly widows. Now, I mean I just think that we have to rethink this whole idea that we ought to automatically transfer money to people once they turn 65. Not only that, but I think it's a key to your thinking to the hopes and dreams that you have. When we passed a new drug benefit bill, did we just try to restrict it to those seniors that had real financial problems getting their prescription drugs? No, you started paying for my prescription drugs also.

I didn't join the Democratic Party to transfer money from the young to the old. It's been so -- it's worked so well up to now, but it just can't be sustained. We're creating this unfathomable burden to our children and grandchildren.

These systems, once we start them, the last Civil War widow only died last year. Two of the last -- the last two Civil War widows died last year. These were young women in 1920s who married an aging Civil War veteran for their pension, I'm sure, not their passion, but they -- they just died last year. Still paying them. Bill Clinton in 2030 will be younger than Ronald Reagan was when he died. So the unfunded liabilities of Medicare and Social Security, according to our Controller General of the United States, David

Walker, are anywhere between 50 to \$70 trillion. I mean that's the same as if every one of us would work for six years and take everything that we earned and put it into a pot of money to pay off the debts that we're leaving our kids and our grandkids.

So as Milton Friedman, and I don't often cite him, but he's right on this: He says if you cut taxes without cutting spending you're not really reducing taxes you're just pushing them off to your kids and grandkids.

Of course we have to do this in the most politically contentious times that we've seen in American history. So I think we really start off sort of with the bedrock and say how do you keep a population healthy? And it's a lot more complicated than I thought it was when I first started looking at this as a state legislator.

And the more you look at it, the more you really see how a good healthcare system is important but secondary to keeping a population healthy. That when you really look at the public health people, the 30 years of life expectancy that we've added last century, the health and human services say that only five of them had anything to do with allopathic medicine.

Really, the great reasons that we are 30 years healthier is because of a -- the public health people because of improved standard of living. The public health measure. Most of the drop in mortality, that's the purple line, happened before we started spending very much money in healthcare.

So just not putting the outhouse too near the well was one of the great advances of public health. But now it's gotten more complicated. A recent White Hall study in England showing England has been following these figures for some time. They showed the class one professional -- They keep class statistics in England -- the class one professional had half the mortality and half the morbidity at almost every age rate as class five labor.

And that was a study in 1947 when they started the national health service and now in the year 2005 everybody's healthier but class one professional still have half the mortality and half the morbidity rates of the class five labor.

And then this latest White Hall study found that it was -- your position in the bureaucratic pecking order meant more to your health than whether you smoked or were obese. I mean the more we look at the determinants of health, they're called determinants of

health, how do you keep a society healthy, that, after all, is the bottom line. Not to say how do we provide healthcare.

So I believe that a key to that, and I know people in this room agree, is providing universal coverage. And to do that, however, we have to convince the conservatives that they have a stake in the uninsured and that their costs can be controlled. But to me that's -- it's just as hard to convince the liberals that some limits must be set.

That we can't do everything for everybody that medical science has invented. So I believe that a doctor will look at something and say is this good medicine. But I believe that what you really do is a system. A system is not good medicine. A system is the technology and training. We're the best at that. But our outcomes are not up to world standards. And we leave 47 million people out of the system.

So I object to the idea that we are called this the best healthcare system in the world. George Bernard Shaw said this so well about the 47 million people. He said the mark of a truly educated person is to be moved deeply by statistics.

I mean those 47 million people are people. And 18,000 of them die every year we're told by the Institute of Medicine because of lack of universal coverage.

So Victor Fukes one of my favorite people, health economist, he says with respect to healthcare a nation can provide all of the people with some of the healthcare that might do them some good. It can provide some of the people with all the healthcare that can do them some good but it simply can't provide all of the healthcare for all of the people that might do them some good.

So that's why I argue we have to rethink our moral geography. We could have every doctor practicing the highest ethical medicine with every patient and from a public policy standpoint I'd still think we'd have an unethical healthcare system. Because we just leave all these people out.

That's not an ethical way to handle it. And healthcare is undergirded by a moral tradition which systematically excludes anything on reference to larger societies.

And unless we take on this sort of voracious appetite of healthcare they'll literally crowd out everything else we'll do in our society. My aging body can prevent your grandkids from going to college, metaphorically.

Because there's just the ability of things of healthcare to do things at the margin is incredible.

I know one thing we're going to have to do is put more self-responsibility on people. Easy to say. Hard to do. But most healthcare hazards, it used to be that we'd get sick for things outside of us TB or cholera something that would come outside of us. Now you are your own best doctor. So much of your health is dependent upon your habits.

And we all know this. But what's happening in other nations is that all of a sudden they're beginning to say, oh, there's some moral as well as financial limits of society's protection of its members from the risk of poor health.

World Health Organization says universal coverage is coverage of everyone but not coverage of everything. Should we have given Mickey Mantle a second liver transplant when he had a co-existing morbidity factor and hadn't stopped drinking?

This is tough stuff. But you gotta get at the frequent flyers of healthcare system. We spend 27 percent of our healthcare cost on one percent of the population. 55 percent on five percent of the population. And so when you really -- you look at this, that doesn't mean that there's not most of those aren't deserving people. My wife had breast cancer 26 years ago.

I'm immensely grateful to a great doctor, a hospital system. But how about Gregory Goins. He's a frequent flyer out of Chicago. One five-year period in the '90s he called 911 1200 times. His emergency room visits and hospital stays cost the taxpayers about a million dollars. When the local newspaper went to them and said why don't you take a cab or something. He said, well, I'm sick and society has a duty to take care of me.

So, increasingly, people are, employers, I listed some of them up. Pepsico, Northwestern Airlines, Gannett are actually requiring employees who smoke to pay extra monthly additions to their health premiums or else join a smoking cessation program. Things like this are in the air.

In London, one in 10 hospitals deny some surgery to smokers and to the obese. Hear the argument. At least hear the argument. It was actually recommended by the British Medical Society. They said: Look, we have a limited amount of money here to do, we've got this massive undertaking with national healthcare. So if someone comes in and asks for a heart transplant or open heart surgery and they haven't stopped smoking, we're not going to give it to them until they stop smoking. Not that we're trying to punish them, but this is the way you get maximum amount of health out of your limited healthcare dollars, is you simply say, look, you've either got to lose weight or you have to stop smoking before we give you this very expensive operation.

The doctor/patient relationship is obviously key. Medical ethics, sometimes the message gets a little confused. This is a husband's note on a refrigerator. "Somebody from the gynecologist called. They said your Pabst beer is normal."

But the devotion of a physician to his or her patient doesn't necessarily make them then a good allocator of resources. If you're going to start down that road of saying we've got to do everything that my doctor says is beneficial to my health, you just can't do that. It's just such an open ended -- it's a bottomless hole if we go down that way. Somebody has to sit down and think about priorities and think about some things that are hard to think

about. I argue that there's a certain amount of medical ethics that are unethical public policy. When you think of all the other things we have to do with limited funds and we are keeping and arguing about keeping somebody alive in a permanent vegetative state.

A system can't have ethical standards which will ultimately destroy the system. So there's a whole new line of thinking here. Providers should not do everything that maximizes benefit to an individual patient.

Since doing so may interfere with the ability of other patients to obtain basic services.

So that takes us to this idea of doctors do their magic by spending other people's money. So somebody has to decide from an insurance policy or a health plan or a community of the status, how do we make sense out of that.

And at this level there's a universal dilemma. The universal dilemma is that very few of us, probably nobody in this room can afford to self-cover. Something might happen to us. So we can't really not have health insurance. It's just not a good idea.

We need risk sharing. But then people will always overconsume free goods. As soon as we set up insurance or government, that's the moral hazard problem that happens.

So we're caught between a rock and a hard place and our efforts to ensure or reimburse for healthcare insulates people from the effects of the market.

So the third-party payment system that encourages this maximum use of healthcare. So one of the things that I'm convinced is that there's a conflict between pushing up the ceiling and expanding the floor. The famous transplant surgeon Tom Starsdale says in his book that he moved from Colorado because I wouldn't build him a new transplant unit.

I wrote this up in Health Affairs, actually. I wanted to expand the floor. I said this is -- wait a minute, our next health priority in Colorado ought to be the people without even basic health insurance and you're doing all of this stuff to -- I don't know whether anybody was right. But there's a conflict between pushing up the ceiling and expanding the floor.

And our current system maximizes demands for medical services paid for by these pool resources within a system that insulates us from the cost. So there's a woman down at

the University of Tennessee Medical School. She's a philosopher, actually. She's come up with this concept called contributive justice.

It's these kind of things that I think are really break-through thinking. And contributive justice says: We're all in the same healthcare system, hypothetically, here. I want to get my PSA tested every six months because I'm cancer phobic. How do we evaluate my request for funds to get my PSA tested every six months? Harvey Moorheim says contributive justice is all members, everybody here would give up a small benefit but receive in return under -- the ability to optimize those dollars.

She says, look, we need a system among us with our pool of money to buy the most health for our pool of money. Makes sense. She said generous compassion to Lamm is inevitably bought at the expense of the rest of you who also make up that pool. So we need some system of priority setting to say what we can do and what we can't do and another way to say that is we're going to have to decide what beneficial medicine can we morally deny people?

And if you don't think that this is -- here's my metaphor. I'm announcing today that I'm running for your school board. My platform is every teacher should do everything for

every student that is beneficial and I'm going to tell the teacher that cost is of no consideration, and I'm going to tell the teacher she has an ethical duty to provide all beneficial care. I'm going to have you pay for it.

Would you vote for me? I don't think so. It's just not a yardstick that we can sustain. Look, lady, you're the one who asked for a famous movie star with dark hair, strong nose and deep set eyes.

Which gets us back to the state of the nation. We have to run a nation of 50 Floridas we have to integrate pensions and long-term care and the healthcare system. We have to control costs. We have to get universal coverage. We have to ask how do we keep a population healthy.

And we have to start off on the fact that we are not the best healthcare system in the world. We don't occupy any high ground. But another reality is that we're finding in public policy is a good healthcare system increases the number of sick people in society.

It's counterintuitive, but it's really true. People like my wife, who is 26 years after her breast cancer, she still takes whatever the new substitute for Tamoxifen is.

In other words, this is what we want a healthcare system to do is increase the number of sick people in society, people that need some support of the healthcare system, and what my generation of doctors has done and has been brilliant, they've reduced acute disease and thrown ourselves in the arms of chronic disease. And chronic disease is very expensive.

I'm going to skip that. I'm going to skip that. Actually, talk about substituted mortality and substituted morbidity. I mean that's what we have. That's what Phyllis Diller says. She says: I hate housework; you have to wash the dishes, change the bed, sweep the floor, dust the living room and six months later you have to do the whole thing over again. Substituted mortality and substituted morbidity is the fact we cure someone from one disease and throw themselves in the arms of another. Nothing wrong with that. Again we want to do that. But this is really one of the reasons -- there's a new big article in the New England Journal of Medicine that prevention might not save us money.

That the reason that prevention doesn't save us money, like smoking saves government money because smokers die seven and a half years before nonsmokers. So on an average that's seven and a half years not paying them Social Security and Medicare.

It's ghoulish, but that's the dilemma the public policy is faced with. Our medical miracles are sort of financial failures.

This New England Journal of Medicine saying all these candidates up for office saying prevention is going to save us money. Well, what used to be inexpensively fatal diseases are turned into I need a new knee. My arthritis, on and on and on it goes, as the body ages.

So I argue that public policy rations both when it denies specific procedure and when it denies universal coverage. That rationing goes from an individual denial to a group maximizing benefit; that if we all put in \$400 a month for our health benefits for us and our ourselves into this group, we would soon set up a committee and say what priorities do we have with that money.

It's what Mark Twain said about Wagner's music. He said it's not as bad as it sounds. I think that's the same thing about priority assessing. The price of modern medicine is somebody has to say, you know, what makes sense for us to do, especially with somebody else's money and when it doesn't.

For society not to ration, would be unethical. Without rationing, healthcare would eat up and devour everything else we want to leave our kids a decent society.

So I am actually in purpose of time I'm going to go right to this question about living with fiscal scarcity. And I think again Harvey Moorheim says that fiscal scarcity is different than commodity scarcity, because every medical decision has its economic cost. Literally every medical decision will now have to be subject to scrutiny for its economics as well its medical wisdom. So rationing isn't going to be where you have only one crash cart and two people needing the crash cart. The new reality is we have to sort of think through in a very sophisticated democratic transparent way what we do in some of these high technology procedures.

And I believe the public policy argument should be how do we obtain the most life and health from the citizens with the funds we have available.

Not only that, having just lost my 98-year-old father, I think that to have a decent healthcare system, that we need Meals on Wheels, health education, telephone reassurance. We need all these other things that relate to the quality of life.

I think ultimately there's a conflict between quantity of life and quality of life that we're going to have to face.

Being in government it's like sleeping with a blanket that is too short. Your shoulders get cold and you pull up the blanket around your shoulders and your feet get cold. I mean that's what it's like. You just can't -- everything we do in public policy prevents us from doing something else.

So [John Kitsober] of Oregon came along and he made this statement. I'm so jealous of him for this statement, because it's so simple. But he said: The legislature is clearly accountable, not just for what is funded in healthcare, but what is not funded.

He said accountability is inescapable. So you can't have your local doctor owning the uninsured but you sure can say the local governor and the legislators have that on their conscience.

But when you look at this, then, it takes, for instance, somebody to talk about some of these systems. I argue that as an illustration the end stage renal disease was passed 40

years ago, 35 years ago. I believe that was unethical public policy at a time when we had 30 million people without basic healthcare. We passed end stage renal disease, the fastest growing use of which, by the way, is people over 85. Would this offend you if we would say don't call the crash cart, don't do CPR, if somebody has widespread cancer with major organ failure or end stage liver disease or uremia or irreversible heart failure, you see the list up there.

Barney Clark, was the recipient of the first heart transplant. Artificial heart. The budget of Humana for the artificial heart was approximately the same the world spent eradicating small pox. Now, I know that was the first one and it's a bit deceptive, you're right, but you get the idea of the magnitude of some of these things. 10 percent of our ICU beds in America, 10 percent of our hospital beds are ICU beds. I've been around the world a couple times looking at healthcare systems. In no other country is it more than three percent. We have 10 percent. Why do we have 10 percent of our hospitals intensive care beds, expensive beds. Number one, fear of lawsuit. And, number two, no other society would take a 94-year-old with congestive heart failure out of a nursing home and put them into an intensive care bed.

An intensive care bed is a salvage bed. It's something when you get in an accident we can save you, not a place to die in.

The most interesting day I spent in healthcare was in Great Britain where we went around with a home health worker. Every woman in Great Britain gets all the prenatal care she needs. She gets three visits postnatally from a home health worker. The wonderful woman we went around with, she wasn't a nurse or college graduate. She was just a grandmother.

And we tried and this is 1992, we could not find an echmo machine in all of London.

And they said, look, we ask ourselves this very simple question: How do you get the most healthy mothers and healthy babies from this part of the budget that we have available to spend? They said it's giving prenatal care to women it isn't a whole bunch of fancy neonatalology. I believe just because something is beneficial or something is effective doesn't mean that it's affordable.

That the price of individual life may be too high a price for the life and health of society at large. Look, when you try to evaluate some of this stuff, please keep in mind the United

States denies more healthcare to more people and we kill 18,000 people a year at least because we don't provide them universal healthcare, there really is no moral ground, or a more higher ground in the United States. That this stuff might sound tough, but these questions about how do we get the most health for society are inescapable.

But Yogi Berra says that's the most unheard of thing I've heard of. Yogi Berra also says if you don't go to people's funerals, they won't go to yours.

This woman is a nun nurse. I said we were at the bedside of somebody that had five fatal diseases, five fatal diseases and she said to me, she said the real issue here is when God calls how much do we argue.

When I die I want to go quietly like my grandfather in his sleep, not screaming like the passengers in his car.

So I would argue, look, life is precious. Of course it is. But it can't be priceless. That it might be too large, and we have to really sort of differentiate preserving biologic human life from sustaining meaningful personal life.

But at some point we cross the moral rubicon. Let me go through these. I don't want to overstay my welcome. The last thing, the other one was when I was 19, somebody told me maturity is a recognition of your limitations. I don't think I understood it at the time. But it sort of stuck with me. Maturity is a recognition of our limitations. And I think a mature society has to say, look, we've got to understand that we can -- the medical science has invented more things than we can afford to deliver to everyone, that's the bad news. The good news is we can still do almost everything for everybody.

Let me leave you with my last one. I believe ultimately age should be a consideration in the delivery of healthcare. I know it's illegal. I know the federal law. But, look, folks, in every religious tradition, in every great philosophical tradition, there's a difference between death after a long life and a premature death.

We owe in a world of limited resources, for some high technology medicine we owe a bigger duty to a 10-year-old than we do to a 90-year-old. You gotta do this, or you're going to do, I think, maybe not, you're going to leave this incredible albatross of debt around our kid's lives, because in a world of limited resources an explicit decision to pay for one procedure for one group of individuals is an implicit decision not to pay for another procedure for another group of individuals.

That there's a new world of trade-offs here between preventive medicine and curative medicine and improved quality of life versus quantity of life and a number of others.

Let me end with my I believe this that public money should maximize the health of the public. Group resources should maximize the health of the group. And individual resources, well, whether we like it or not people can spend their money like they want on themselves. The important thing would be that we can't do everything for everybody but we can still do a lot much more than we're doing now.

And I leave you with this thought that was America's poet laureate at the time, Howard Nemerov. He said: Praise without end for the go-ahead zeal of whoever it was invented the wheel, but never a word for the poor soul's sake who thought ahead and invented the brake.

Ladies and gentlemen, we need some brakes. Thank you so much.