



MOUNT SINAI
SCHOOL OF
MEDICINE

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Good afternoon and congratulations to the class of 2011, and to their families and friends.

Robert Kennedy during his last campaign repeatedly quoted George Bernard Shaw. Kennedy would say, "Some people see things as they are and ask why? I dream things that never were and say, Why not?"

As you begin your careers, I want the words of Shaw, immortalized by Kennedy to reverberate in your ears as you shape the health care of your generation. To repeat, "Some people see things as they are and ask why? I dream things that never were and say why not?"

You have inherited a national healthcare system that is broken. Federal and State governments realize funding for Medicare and Medicaid are unsustainable. All sides of the political spectrum agree we must bend the cost curve. The sides only differ in how large the cuts and where they come from. But all plans are most aggressive in cutting payments to hospitals, and the hospitals most impacted are hospitals like ours, urban academic medical centers that, in part, serve impoverished populations. Ultimately our patients are being asked to make the greatest sacrifices.

Surely we will have to bend the cost curve. Surely we need find a way to sustain Medicare and Medicaid without bankrupting state and federal governments.

The question is how?

We know what is being proposed can be enormously damaging.

Against this background let us, like George Bernard Shaw and Robert Kennedy dream things that never were and ask why not, rather than accept as inevitable what is. Let me share with you some of my dreams.

The cost of maintenance for a kidney transplant is about \$20,000. According to the United States Renal Data System, the savings to Medicare for each patient who does not progress to dialysis is estimated to be \$250,000 per patient. So a single transplant can produce savings 10 times greater than what it costs. But the vast majority of patients cannot get transplants. The central question is, Why not?

The answer is twofold:

- In the U.S., we do not assiduously encourage organ donation, and we do not incentivize donors.

- In the U.S., people are automatically assumed to *opt out* of organ donation unless they have a card or an advance directive specifying donation. In other countries, people are automatically assumed to *opt in*. They must specifically state their wishes in order to opt out.

Conservative estimates put the cost of dialysis at 100 billion dollars in ten years. Changing our countries policy to favor automatic opt in, would likely save a half a trillion dollars in health care costs over the next 10 years, and far more over the next 10.

In a benevolent society like we wish ours to be, but a society that is nonetheless running out of resources, we must dream what could be — and reform the fundamentals of our transplantation system to encourage donation.

Here is another situation that is, and that, with a little dreaming, could be transformed into massive cost savings. Obesity-related diseases, particularly type II diabetes accounts for nearly 10 percent of all US medical spending, or \$147 billion annually. Over time if nothing changes, three-quarters of Americans will be overweight by 2015

If Americans weighed on average today, what we weighed approximately 25 years ago, over the next 10 years it is estimated we would save 1 trillion dollars in health care costs .the entire amount generated for Health Care Reform by the ACA

It has been argued that a "sugar tax" would reduce consumption, as a society we have accepted the notion that we tax tobacco products and alcohol. We do so, in part, to discourage use and studies show such taxes are effective in altering behavior.

To date every effort to impose a high fructose or sugar tax has been defeated. We must ask Why not? And become the vectors of change.

I want to turn to another example of what we can dream. In the Medicare system, the government is currently prohibited by law from seeking bids from drug companies for their products. The companies essentially set the price.

Is there a better way? We need look only as far as the Department of Veterans Affairs, which by law must be sold drugs at the lowest price sold to any provider. As a result, the VA receives a discount of more than 40 percent off the list price.

According to Boston University department of health care economics if the federal government were allowed to follow the VA's purchasing policy for the Medicare

system, the U.S. could save some \$14 billion annually in what it spends on prescription drugs annually — \$140 billion or more over the next decade.

Why not? Why should the savings *not* come by negotiating the lowest price with the pharmaceutical companies? Why should resolving this issue be only a dream?

Another area ripe for questioning is how we encourage innovation in drug discovery. Diseases such as Alzheimer's and Type 2 diabetes, diseases that are so pervasive and costly, must become a national priority for innovative drugs. The extrapolated cost of taking care of Alzheimer's patients within the next 20 years, will bankrupt the Medicaid system. And the complications of type II diabetes, like kidney failure, heart disease, and vascular complications, will cripple the Medicare system.

What if we developed therapeutics that could delay the onset of diabetes by 10 years? Each year, some 1.9 million Americans are newly diagnosed with diabetes, and the annual cost of the disease is approximately \$10,000 per patient, per year. If we could delay the onset of diabetes by ten years, the savings would dwarf many of the proposed cuts in Medicare now being debated.

A drug that could delay the onset of Alzheimers Disease by 10 years would save up to a staggering \$100,000 per patient, per year for those patients receiving nursing home care. Add it up, and we would realize staggering savings to the health care system.

I ask why can't we change our government's patent laws so that the first drug that delays the onset of these public health priorities is not treated in precisely the same way as the seventh antidepressant that blocks serotonin reuptake. Unless we change patent law to really encourage innovation, unless we align patent law with our public health needs we will be mired in new drugs for erectile dysfunction, seasonal allergies, and insomnia. Drugs for these conditions are low risk to make, and have a good return. Simply put, we cannot treat all new drugs alike, if we are truly committed to bending the health care cost curve, and capitalizing on the opportunities made possible by biomedical research.

Let's look at how we die in America. Patients facing serious or life-threatening illnesses account for a disproportionately large share of Medicare and Medicaid spending. At Mount Sinai we know that patients who receive palliative care incur substantially less hospital costs than patients who receive usual care. Palliative care recipients compared to standard of care patients spend less time in intensive care, are less likely to die in ICUs, are more likely to receive hospice referrals, and have families that are more satisfied with the care they received.

If every hospital with 150 or more beds had a fully operational palliative care consultation team, the reductions in Medicaid hospital spending in New York State alone could be as high as a quarter of a billion dollars annually. The savings in Medicare would be even more dramatic. . . and this is NYS alone.

So, why not? Why not reduce spending by ensuring palliative care consultation at every large hospital throughout the United States? In an era of ruthless cost-cutting, this is a cost-savings effort that is in line with the wishes of patients and their families, one that holds the promise of humane, compassionate alleviation of suffering. Can we not dream of what can be and ask why not?

These are just a few examples of how the debate on how we can bend the healthcare cost curve can be dramatically changed if physicians challenge the current stale thinking. Thinking that is often driven by people who are not responsible for delivering health care. Today, I have only discussed a handful of possibilities. There are other strategies to reign in health care costs without harming patients, physicians and hospitals. For example malpractice reform, the management of the Medicare formulary, and the institutionalization of the elderly. Suffice it to say, there are real opportunities for massive savings, but it requires us to fundamentally rethink what we are doing.

This graduating class of physicians and scientists cannot accept things as they are. Deep and profound changes are already underway. If you sit on the sidelines, the future of healthcare will be shaped by people who are not experts in the field, people who have simplistic, uninformed, and often philistine solutions.

I will conclude with another quote from Robert Kennedy. He said, "The future does not belong to those who are content with today... Rather it will belong to those who can blend vision, reason and courage in a personal commitment to the ideals and great enterprises of American society."

That future, our future, is now in your hands. Do not to be content with *what is* — but dream things that never were and make them so.