Talking Pop Health
Episode 14: Robert Friesen of PerformInsight LLC
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ERIC: Welcome to Talking Pop Health. I'm Eric Tower, an attorney at Thompson Coburn. Last time we talked to Hector Torres of Focal Point Partners about the outlook for 2022. Today we're going in a whole new direction. We're going to do a deep dive about what Pop Health really is and what we need to do to achieve outcomes and health for the whole country. Sitting across from me is Robert Friesen and he has a heck of a lot to say. Let start with, Robert, a little background about you?

FRIESEN: Sure, Eric, thanks for having me. I have been lucky to have a varied career over about 40 years. First I was a child and family therapist. Then I went back to school, got my business degree and did 20 years in traditional consulting with Anderson Consulting EY, KPMG and other organizations doing strategy, M&A and operations work. I started my own firm because I wanted to get involved in some things that were a little more creative and I also started working in other industries and seeing how healthcare isn't really that different. Over time I was also the CEO of a telemedicine company, I worked for Performance Management Company and now I still do consulting work and serve on several boards of advisors and I'm the Chief Financial Officer for a company that's working on a device that improves the lives of victims of domestic violence and judicial witnesses.

ERIC: Let's drill down on Pop Health. What do you think about population health at this point? We've had a lot of conversations, now's your opportunity to kind of let the world know what your thoughts are.

FRIESEN: Well what a great kickoff, Eric. Thanks. I'd like to answer that maybe through three topics that we can address today. First, I think population health is a bit of misnomer for the way it's practiced today. Second, I don't think we have alignment among the participants. So we can implement something on a population wide level. And third, I think that achieving a health population is going to require transformational innovation on a national level. It's time to begin to set it up and I'd love to see three or four future podcasts detail the model and the implementation Today, I just want to address it on a fairly high level.

ERIC: So when say population is a misnomer. Are we talking about the triple aim, the quadruple aim, what are we doing here?

FRIESEN: Well, if you're talking about a healthier population, you're talking about something that's very broad-based. In our case, probably national. And offers a foundation for a healthy life for anyone in any segment of the population. So this doesn't differentiate throughout the population. Population health can't be divided up into fragmented elements and activities because that weakens the programs and creates unnecessary costs and reduces the ability to reliably measure the outcomes and

improve programs. At its core, population health is about providing resources and inspiring people to internalize healthy lifestyles. This is very different from healthcare. We need to begin by developing a fairly simple set of guidelines that refocus the population on four health building blocks. Nutrition, exercise, sleep and managing high risk behaviors, like driving without seatbelts and leaving guns unlocked where children can reach them. Personal mismanagement of those building blocks is the root cause of about 75% of hospital admissions.

ERIC: So deep down, are we talking about nationalizing the entire healthcare system? Are we talking about taking the local systems and sort of concentrating them across the country or are we talking about something else altogether?

FRIESEN: I think this is where I diverge from the current practices. I don't think we talking about something that involves the healthcare system as a primary participant. And a second population health strategy is something that needs to be considered outside the provider and private care framework. That framework has been fairly expensive for us over time and has really given us the ironic result of rapidly increasing costs and declining the state of national health. Let's just back up for a second and set the context better on health in American and let's take one sort of glaring example. In 1980, we had about a 13% national obesity rate. Today the CDC estimates somewhere between 37 and 42% of the population is obese. So over that time period, about 40 years, the nation's gone downhill convincingly. The U.S. also ranks 12th in the world in terms of prevalence obesity. And you may think that 12th is not so bad but there's 195 countries and the top 10 in obesity are South Pacific micro nations like the Cook Islands and Conga. So when you think about the top 10 being tiny and number 11 being Kuwait, being number 12 is pretty alarming. We're also fattening up the next generation of Americans. Twelve percent of kids aged 2 to 19 are obese. They're on a clear trajectory to adult obesity and more rising healthcare costs as obesity enables all sorts of other problems, orthopedic, cardiopulmonary, oncological and others. When we look at the decline of health in America, it's not just obesity. It's other things as well. The drug overdose rate clearly illustrates that there's a large segment of Americans that are on a destructive path. In 2019, Moody's also published an extensive study on millennial health and for their age, millennials have very high rate of both physical and mental health problems. Overall, we operate under a belief, that's probably a fallacy, that people have their own best interest at heart. But Americans aren't really responsibly managing their health and they're not accountable for the tremendous excess expense that goes into healthcare. Poor health has become the new normal and people use portfolios of pharmaceuticals to improve the health but they don't reach a normal level. We're at the point where we really have to figure out a way to reverse this. American believes that having unlimited and immediate access to healthcare and I emphases the suffix "care" at the end there is a definition of good health but it isn't. We need a new population wide starting point.

ERIC: So if the healthcare community isn't the answer and isn't really the focal point, how are we going to interact with people to accomplish this?

FRIESEN: America has a strong history of mobilizing it's population to achieve national missions. Public health is successfully implemented national programs that have been built through communications and positive and negative incentives. Consider a really simple example, seatbelts. Cars didn't originally have seatbelts. Then they were put in as an option. When they were introduced they were a curiosity. But over time, through communication and eventually laws, seatbelts grew and were almost universally accepted. If a driver's caught not using a seatbelt, a negative incentive occurs, the driver's fined. About 90% of drivers used seatbelts in 2021. It took a generation to get there but we're there. Modernizing and properly funding public health offers a lot of options for building effective national health programs. We need to move the population health idea out of provider networks where people visit their doctor maybe once or twice a year and into something that can prevail in places where people live their day-to-day lives. It has to be in their homes, their communities, in their grocery stores, in their workplaces, their schools and so on. And it has to be reinforced to engrain and expand health behaviors. Just because there's a national initiative or a national mission to create a healthier population doesn't mean that the people are necessarily legally bound or forced or watched to get healthier. It's a matter of giving the entire population the resources incentives that they need to adopt a healthier lifestyle. This is not something that requires physicians or hospitals. This is a challenge in managing behavior and that's not a skill that health systems are set to do. Providers are trained in episodic, interventional office space medicine. Population health is something that has to occur on a more universal and frequent scale.

ERIC: So is this a variant on behavioral economics? Are we, University of Chicago, you know, creating incentives for people on a macro level and hoping that they do what they're supposed to?

FRIESEN: That's absolutely part of the model. Incentives themselves are part of reinforcing behavioral change. We already use positive and negative incentives in health but it's spotty and typically poorly implemented. People are rewarded by their health plans for exercising and experience negative incentives such as higher health premiums for behaviors like smoking. But the way incentives are applied today, people focus on immediate rewards instead of lasting behavioral change. Incentive management is a science rooted in behavioral psychology. It probably desires its own podcast to understand how the underlying behavior modification and behavioral economic principles work but I would definitely see bringing experts in both of those areas in, in future discussions, to see how we can make this work.

ERIC: So how do you go about interacting with the population at large?

FRIESEN: We need to transform the approach that we're taking to population health. Today's episodic approach is insufficient. We have to approach the population overall. Get broad communications out and create a national mission to align the population behind adopting healthier lifestyles. This is consistent with the large scale of kinds of public health programs that we've seen in the past. Positive and negative incentives can reinforce the programs. First we have to come to grips with the fact that healthcare is not health. Healthcare has built an unrealistic expectation that if you go into the healthcare system, it can treat whatever ails you and return you to

normal. But much of the population never returns to normal. Healthcare just stabilizes a declining trajectory. This creates a misaligned focus on health because people think that they go to the doctor for wellness visit every year and that they're managing their health in the best possible way. But they aren't managing their health, because they're not managing their lifestyle. Instead, they're managing their health issues. And this is a very expensive and ineffective way to manage health. And it's not working.

ERIC: So let's boil all this down. You're basically saying the medicalization of healthcare is detrimental to the overall health of our population because people turn to their physicians and they're not empowered; they're not taking ownership or they don't believe they can take ownership of their health and hence, on taking the steps that they should to create optimal healthcare. Is that what you're saying?

FRIESEN: Absolutely. Health needs to be in people's home, communities, grocery stores and so on. Entry into the healthcare system should be a last resort. I support getting an annual physical but the healthcare system is the wrong place to manage population health. You know it's also a very uncoordinated mix. You've health systems, Wal-Mart, alternative providers, this huge mix of things that individual combine along with the health stores that they grew up with. This has created a very uncoordinated and expensive way to manage the basis of health. As several of your guests have noted in the past, hospital systems are primarily in the hospital business. They may have diversified through medical groups, wellness resources but their balance sheets rely on maintaining hospitals and keeping people in beds and negotiating contracts based on that 800 pound gorilla. This isn't the foundation for effective, affordable, healthy lifestyles.

ERIC: Some previous guests have tried to address some of this. We had Deb Giesler on from Active Healthcare. We had Mark Nolan from Hen[?] Health. I also note there are a lot of Medicare Advantage plans that are moved away from episodic care and they do quite a bit on the preventive and health maintenance side. There are some innovators who haven't been on this program yet; doing a lot of rounds, total care, wellness, even what some might call recreational activities. Is it your position that that is insufficient?

FRIESEN: I think it is insufficient because it still relies on episodic involvements. I don't think it's broad-based enough. Medicare Advantage plans have incorporated incentives and wellness programs into their plans. They may attract a healthier population of traditional Medicare. So when they say X percent of their members are participating in free or discounted programs, many of these members may have already been participating in similar programs. We may see an incremental improvement in health but it gives Medicare an opportunity to control the cost of the plans by sourcing it out to private health plans that develop ways to compete in the system. But I wouldn't say it's a substitute for population health. Numerically, Medicare is a large segment of the dollars that are spent in health. But it's a smaller segment of the population. So it's nice to be able to point to it and say that we're seeing a little bit of uptake here. I'm just not sure we really see a significant change between the way

Medicare Advantage members manage their lives as a result of being in the plans.

ERIC: So what you're saying is the people who go into their Medicare programs are the ones that are already receptive and we're not really moving the needle? I mean there are also, I will note, a lot of workplace healthcare plans that provide incentives for stuff like walk a mile today, get some extra points, so people are trying to do this, right?

FRIESEN: That's true. But if you look at the workplace plans, the longevity of people in those plans tends to be very short. The average participation in a program is 6 weeks and after a six week program typically people revert back to their previous behaviors so I'm not sure that they're necessarily a good indicator where we could get with a more universal and consistently implemented program on a national level.

ERIC: Yeah and I will support what you said. I know that there's a lot of literature showing that those workplace plans actually lack effectiveness over time. Plenty of academic research there. But let's turn to something else here. You and I over the course of years have talked about safety net hospitals and the role they play and the fact that, frankly, they don't get rewarded or even paid for the services they provide to their communities and how vital they are in their communities. Let's just touch on that.

FRIESEN: Sure. I think the safety net hospitals are really caught between a rock and a hard place. They underfunded. Typically they have very, very risky cash flows, maybe with two or three days of cash on-hand; as we see in some of the hospitals in Chicago and it's very difficult for them to really implement any programs at all. If you underlaid those with a much broader, national program and then started to realign some of the resources safety net hospital offer to their populations based on connecting to the public health programs in a better way, you can probably reduce the health iniquities, the use of in-person resources and improve the overall health and contribution to populations by focusing on primary care that's connected to public health rather than on some of the higher level services.

ERIC: Well how are we going to do that?

FRIESEN: The first thing I think we need to do is realign the way that we're going to go at the whole population health model. I don't' really think of the provider sector as being one of the primary pieces of the planning here and particularly the safety net sector which is a specialized sector on its own so, if I could, I'd like to sort of defer that question until we have a better model worked out. I do know that the safety net network needs to focus downward as I'm suggesting with a broader public health program and start focusing on the wellness initiative, the lifestyle changes and so on, that people can make in the communities before we start focusing on reengineering the actual safety net networks.

ERIC: This is a bit of a comment but I'd like you to respond to it. A Machiavellian person would say that we keep the safety nets around because the large academic health systems don't want those people in their emergency rooms but they want every other piece of that care. They don't want the uninsured people flooding in and crowding out the wealthy

people from the suburbs, or wherever, so there's enough resources given to the safety net hospitals to kind of divert that population but there isn't enough given to them to let them succeed and thrive. Thoughts? Comments?

FRIESEN: I'll cite one statistic which is that in Chicago, people who live within the market areas of safety net hospitals, the majority of them leave their communities for healthcare. I think it's something like 60% of the people living in safety net areas leave their communities for healthcare. I think that they're voting with their feet right now. The whole set up right now just doesn't work. The population has figured it out and I think that until we make some changes in the quality and the accessibility of the resources in the safety net communities, we're not going to see a change in emergency rooms are going to be continued as their venue of choice for primary care and anything up from there.

ERIC: Let's pivot slightly. Take an example such as Kaiser. Kaiser takes full financial accountability for its patients, in California it operates its own hospitals, its own medical group and in the interest of full disclosure, I will readily admit that I was a Kaiser kid growing up and I never really had an issue; sometimes the long waits. But it seemed to work pretty well. What are your thoughts there?

FRIESEN: Kaiser has been excluded from health organizations for decades for a reason. Because Kaiser is the closest you can get to public health without becoming public health. It's a strongly primary care driven organization. They have managed to keep costs low but to be a Kaiser member, it's a real cultural shift for people to survive as a Kaiser member. They need to be willing to adopt the primary care model. They need to be accountable to a degree for their own care and Kaiser will give them the resources to do that. But it really is sort of a preamble for getting into a broader, accountable public health model.

ERIC: So do we nationalize Kaiser? Would that be a step in the right direction?

FRIESEN: I think that capitation is too big a fight for the healthcare system to take. Again, I shy away from using the healthcare system as the foundation for what needs to happen to improve population health. It really is something that needs to happen on a public health basis. On a behavioral management basis and the provider networks just are not the venues. They are not tooled to do this kind of approach with the broad population base. The political issues around capitation, the change management issues that you have in moving the existing healthcare delivery system from a current episodic payment basis, even a value based care payment basis to a capitated basis, making them focus on health and so on, it's extremely disruptive to the economic model and I don't think that that's a realistic way to think about doing public health going forward.

ERIC: Well, let's go a little deeper there though. There are organizations that are taking full risks in providing the care along the entire continuum to their patients. If you've got these Medicare Advantage plans, there are private equity companies that have definitely moved into that space and are actively, rapidly growing, and if they're getting paid a per member, per month fee, they have every incentive in the world to kind of keep these patients healthy and make sure they get the care they need.

FRIESEN: Yeah, and we've seen those kinds of initiatives since the 80's. You may recall the debacle in the 80's where capitation came in, a few organizations tried to take it. I mean, even Harvard Pilgrim health plan had problems with capitation because they underestimated the risk and I think that underestimating the risk today when you've got a population that's so much unhealthier than it was in the 80's and expecting any traditional provider organization to migrate over to capitation and suddenly start managing health instead of managing revenue coming in is just completely unrealistic. The change management period that you'd be looking at there would be over the course of generations and during that change management period, I think that you'd see the glacier just running over the rocks on the beach. I think that the old way of doing things would prevail as it has in the past and there would be too many ways of creating uproars both with the providers and with the populations they serve who have always responded to things like capitation and even things like social security and Medicare, people said were communist. They were going to destroy the fiber of the American healthcare system and they were going to take apart the fiber of the economic system. It wasn't the case but people get very fearful of this and healthcare is a highly charged political issue. I don't think that expecting the healthcare system to change in that degree is the way to do it. Another problem is that the healthcare system is extremely expensive. To expect that the foundation for managing health is going to be a $145 primary care visit is just asking for trouble. I mean, we're already at a point in the U.S. where healthcare expenditures at $12,500 per person on average, are more than twice other first world countries. You look at countries like Japan and Austria and Norway, they're in the $6,000 range and their healthcare indicators far surpass those of the U.S. They have better management, well they have lower incidents of chronic diseases. They have lower incident rates of episodic illness, obesity is lower; the U.S. has gone completely off the reservation as far as costs goes.

ERIC: Let me pick on the HMO piece a little bit; what happened in the 80's and a little bit into the 90's. In my experience, what happened is you did have physicians who took capitation for the physician services and that was sometimes just primary care but sometimes it was primary care and special. What wasn't capitated were the hospital funds. And the idea was the physician would serve as a gatekeeper and stop the people from going to the hospitals and that led to a significant backlash. I think nowadays with the advent of big data, and electronic medical records, there's a way to unify the universe that care for these patients and actually come up with ways to control care costs and once the physician realizes that they're fully responsible and accountable for all the costs, you can do a lot more on the prevent items, you can do wellness, diet, activities. There are a lot of things now that are possible that weren't possible in the 1980's. So I'd love to get your reaction there.

FRIESEN: I just don't think it fits into the medical practice economic model. I appreciate that a lot of physicians, primary care physicians in particular, a lower complexity specialty physicians, have taken capitation and they probably manage those population basis a little differently than they did before but that's a very small scale approach. You end up dying the death of a thousand cuts with that one because you're constantly trying to convert physician practices over from pay per unit types of reimbursement over to capitation and it change the way that they practice. The physician

practices can't, many of them can't sustain that and they also don't have the support levels, the systems and so on that they need to support that. Another thing that's different from the 80's is the population is nowhere as healthy as it used to be in the 80's. So capitation actually brings many more risks with it. If you're dealing with physician practices on a onesie basis or even large physician groups like some of the health system affiliated groups of hundreds of doctors, it's still a very, very small portion of the population. If you look at a large health system in a major city, they might have a 15 or 20% market share in that city. That doesn't give them much leverage to actually go and create change on a city-wide basis which is what they really need if they want capitation and improved health to change in a significant way over time and to succeed. Otherwise they're going to end up creating an unfair competitive situation for themselves where they'll be the ones who accepted all the capitation and it's not going to be good for them in the long run.

ERIC: Let's look at the primary care doctors and we can overlay the health systems are not. If I'm a primary care doctor and I stop one patient from going to the emergency room because they have asthma, where if I stop a diabetic episode, I'm saving the health, well the country, payors, thousands and thousands of dollars right there. Right there there's an incremental step that doesn't exist in much of the country. What's the problem?

FRIESEN: It's a onesie strategy. So I'm going to change one doctor and then I'm going to change one other doctor and one other doctor and in the end this doesn't give you enough of a critical mass to really make a significant difference. You're changing things a thousand dollars at a time. Where with a broad public health program, you could be changing things on a trillion dollars at a time. If we implemented better public health programs which admittedly are going to take a generation to really take effect. We need to start with a generation that is not as mired in the current health situation as the boomer and probably the gen-Xers. If we start with a much broader population base than that and try to move them along, it would be nice to be able to move a few doctors along and a few health systems along with more innovative delivery systems but it's not large enough scale to really make a difference in terms of the health of the population. So I think that we really need to focus first on public health and bring the providers along rather than focusing on the providers and trying to implement smaller scale public health programs.

ERIC: So why can't we do both? If I can get physician groups, predominantly primary care across the country that are big enough that they can start doing this, that becomes one prong to address this issue and then we also do a more global population health on a national scale to tend to what you're talking about. Do you see a problem there?

FRIESEN: Yeah, I do. There's a reason why Kaiser hasn't proliferated more of the country. And that's because the people in other market, other than California and a couple of other markets where Kaiser has succeeded, just don't think that way and they're not going to enroll. There's going to be all sorts of political issues that arise and it's going to fail and then that'll give everybody an opportunity to point fingers and say Oooo, it failed. Now they may be pointing fingers for reasons that were fallacies. But the cultural change that you need to make to make that kind of a change

based on the care that people get and the coverage that they have and the way that healthcare is delivered to them; everybody in the country knows that that's political suicide.

ERIC: So let's turn to – and I really appreciate you raising all the behavioral economics scenario items I enjoy reading on, personally. But you're really focused on this sort of long term systematic change using behavioral economics. What do we need to do to get this thing off the ground then if it's not going to be done through primary care?

FRIESEN: I think, again, we need to refocus our resources on public health and behavioral economics. It's a matter of building national programs of giving people the resources they need to understand what it is that creates a healthy lifestyle to making this available to them where they live at home, where they work and so on, to setting examples, to providing incentives. You know incentives don't have to all be positive. It's doesn't have to be you get a tchotchke because you got your vaccination. It can be a matter of well, you decided to smoke and you have avoidable obesity, your healthcare premiums is going to be a lot higher than your next door neighbor. That kind of incentive works as well. It worked very well with Medicare in terms of getting the elderly to enroll in Medicare Advantage and other types of plans that better managed their health. And it can work nationwide as well. If you consider that we could, if we brought ourselves back to other first world cost limits, if we save $6,000 per person over the course of a generation and inflated that, it wouldn't take long for people to realize that there is a reward associated with managing their health better. This again brings me back to understanding, really taking the steps initially to understand what it is that puts people on such self-destructive health trajectories. It could be carelessness. It could be denial. There are a lot of different ways that this happens. We've done market research for clients in markets around the country to understand the health of their population and what we found is that probably about 20% of people are healthy and 80% of people are somewhere on the continuum from needing a few things to improve their health, you know lose some weight and manage a few other health issues to just being train wrecks where you don't have an opportunity to bring them back again. I mean these are people who have just chosen to basically destroy their lives and they've done it. It's not going to be a matter of doing things on a provider basis, one by one, to make that change. It's going to be a matter of developing very broad based programs and then basically rebuilding the way that we deliver wellness and health based on those health programs.

ERIC: So how do we start?

FRIESEN: I think that the only thing is important to have criteria for success. I put together some imperatives and I hope we're going to be able to use as we continue this conversation. I'm not the ultimate resource on this, I'm proposing something on a very large scale. Here are some guidelines. I have 11 guidelines that I think that we need to follow. First, I think we need to rethink the population health model. We can't use the existing provider based model. We have to adopt something that's bigger scale and more unified. Second, we need national standards and we need to translate those into a mission that people internalize and partners like employers can support through aligned programs. And this is part of

where behavioral economics begins to play a role. Third, we need to have effective positive and negative consequences. I mentioned before that if people choose to smoke or otherwise possibly set themselves up for costly services that are avoidable, they should probably end up with a negative consequence just as people who are caught not wearing seatbelts end up with a fine. Fourth, population health needs to be based where people live. We have a lot going on now in terms of smart phones, in terms of internet, in terms of new communication processes, and we have a lot of ways of connecting with people for programs like this and helping them on a day to day basis. But we have to recognize that this is not something that occurs in a hospital or a physician office. People need to be able to access this at a very low cost and 24/7. Fifth, it has to be very simple so people can understand it. You're not giving people 20 instructions at the last minute in a physician office and sending them home and by the time they've said goodbye to the receptionist they've forgotten 19 of them. Sixth, it has to be something that costs pennies per person to implement. This is where public health really comes in. When you're trying to do wellness in a $300 annual physical, you're perpetuating in the effect of $12,000 per person, per year, tier model. Seventh, we need to ensure that people have ubiquitous access to population health resources and this is where innovation can create an advantage when blended with public health and behavioral economics. We saw that during the COVID epidemic when we integrated resources from social media, from CVS and Walgreens and other sources and came up with an integrated program. Next, we need to align management of those programs across health plans. Medicare Advantage plans are based on similar strict program standards and health plans have found ways to differentiate their offerings there so this shouldn't threaten the health plans much with the way that they compete. To do this we've got to pay for it and we have to reallocate capital that's currently going to primary care, public health programs and other expenses. As population health improve and employer health expenses are reduced, we may be able to propose an expense tradeoff if employer's net result is positive. And finally, we have to understand we're dealing with something that's going to take big thinking. This isn't an incremental shift. This is a transformational shift and we need to think in terms of large scale generational change. It's one of those big hairy audacious goals America is so good at.

ERIC: Okay, well, how do we get the ball rolling today then? I mean this is a visionary plan. How do we make it reality?

FRIESEN: I think getting it started is very low cost but we really need to define the question that we're asking and bring some new people into the room. Because the way that we're doing it now is clearly not working. The cost trends, the American health trends are all headed in the wrong direction. We need to understand the subject that's making this all happen which is individuals. It's individual decisions on health not healthcare that's going to make it happen. We need world class thinkers and public health and behavioral economics to start to define the framework and build the potential solution hypothesis. We can include other stakeholders in the game at another time. This initial group will set the foundation for understanding the population we're dealing with. How do we segment? What are they doing that is causing healthcare to go awry? How can we get those behaviors to change? Who will be the early adopters? The

early majority? The late majority? How do we accelerate through the adoption curve?

ERIC: So do we start with a government initiative or is this the private sector? Is this at a state level? Is this HHS? Congress? Who does this?

FRIESEN: Ironically, in America, Medicare has actually been the most innovative healthcare organization going. So I would certainly see, you know, when you look at Medicare and Medicaid, they cover about 40 or 45% of national population. Medicaid's pretty fragmented so it's not as powerful as Medicare in terms of implementing programs but there certainly is an opportunity to get government involved. There's smart people in government healthcare. There's smart people in private healthcare. It's really a matter of pulling the people together and saying, look we're going to do something new here. What we can't afford to do when we start thinking about this is say we're going to include people to protect interests. Protecting those interests will suck the solutions down the drain. You need to have the courage to rethink it. We can be selectively inclusive as we develop a framework but we have to avoid falling back into what we know.

ERIC: Fair enough. Any last thoughts as we wind down?

FRIESEN: I think it's a very exciting undertaking. We've got an opportunity to rethink things. We can do it, certainly, within a very reasonable cost budget. We can start to develop pilot programs. There's a lot of ways we can do this and we can do it without harming the healthcare system but with migrating it and certainly the smart healthcare providers are going to see the change that's on enroute and accommodate it. What we really want to do is get our healthcare expenditures and our health lifestyles to where other first world nations are. That's something that's right in front of us. It's certainly achievable and we can do it without creating political or financial implications for the population at large or the provider network.

ERIC: Wow, this is certainly eye-opening. I appreciate you taking the time to come out and frankly, if anyone listening to this wants to reach out, we'll make sure we post contact information. You can engage in a dialogue directly with them because I don't doubt that there will be people who want to have something to say about this.

FRIESEN: Well, I look forward to that, Eric. Thank you.