Fixing Healthcare Podcast Transcript

Interview with Ian Morrison

Jeremy Corr: Hello and welcome to the new Fixing Healthcare podcast series, Breaking The Rules. I'm one of your hosts, Jeremy Corr. I'm also host of the popular New Books of Medicine podcast and CEO at Executive Podcast Solutions. With me is Dr. Robert Pearl. For 18 years, Robert was the CEO of the Permanente Medical Group, the nation's largest physician group. He is currently a Forbes contributor, a professor at both the Stanford University School of Medicine and Business and author of the bestselling book, Mistreated: Why We Think We're Getting Good Healthcare and Why We're Usually Wrong and Uncaring: How The Culture of Medicine Kills Doctors and Patients. All profits go to Doctors Without Borders. If you want information on a broad range of healthcare topics, you can visit his website at robertpearlmd.com. Our guest today is the New York Times bestselling author and nationally renowned futurist, Ian Morrison.

Robert Pearl: Ian, welcome to season seven of our Fixing Healthcare podcast.

Ian Morrison: It's a delight to be here, Robbie, and I was on the early days of the original series, so it's a joy to be invited back.

Robert Pearl: This season's theme is Breaking Healthcare's Rules. The premise is that the current American healthcare system is so broken that small tweaks won't be enough. And that making real improvement will require breaking its rules. By rules, we don't mean the written ones and textbooks or the ones published by regulators. No, these are the unwritten rules, the norms, expected behaviors and ways of thinking that doctors learn in medical school, residency, and carry with them throughout their professional careers. And as healthcare's leading futurist, I can't wait to hear your thoughts on the outdated rules that we need to jettison. A great place to start would be with your concept of the second curve. What do you mean by that? And why is it important?

Ian Morrison: Robbie, I have been a student of structural change in society now for 50 years, people say, how did you become a futurist? My undergraduate major at Edinburgh University was geographic and economic change in Scotland, 1580 to 1830, which is incredibly useful, but actually is a useful training because in the latter part of the 18th century, Scotland was completely transformed from post rebellion, post Bonnie Prince Charlie, if you know your history. And was completely transformed and became the crucible of the age of enlightenment. So, I've been interested in structural change for a very long time. And when I was at the Institute for the Future, we were working with a lot of clients who were experiencing, and not just in healthcare, in fact, it was more common outside of healthcare that and the premise of the second curve was embarrassingly simple.

Ian Morrison: The argument was that most businesses and most industries were going along quite nicely on their first curve, which is the base business. It's the business, they know how to operate on a daily basis, but they have a sneaking suspicion in their gut that it's going to decline in either absolute or relative terms. It might not be a decline in revenue. It might be growth rates or margin and be replaced by a second curve, a new business or a new way of doing business that is radically different from the first. And the dirty little secret of futurism, I think is you cannot predict the future. You can think systematically about it. And my old mentor and boss, Roya Mora, taught as well that there's a natural human tendency to overestimate the impact of phenomena in the short run and underestimate it in the long run.

Ian Morrison: And that really what the second curve is about is to kind of unpack what was driving those fundamental long term changes. And what we kind of identified were new technologies like the internet, new consumers who are more skeptical and demanding and new geographic markets globally that were going to transform the planet and that kind of rippled through every industry at various rates. And so that in essence probably was the argument for the second curve. You have to be attentive to the old curve going away eventually and the new curve taking over. And you had the great Malcolm Gladwell on, I know he is a good friend of yours. I mean, Malcolm really described in the tipping point, those inflection points between the two curves.

Robert Pearl: To move from the first to the second curve, Ian, what are a couple of rules that you believe medicine will need to break?

Ian Morrison: I think the resistance of an industry, because I think the unwritten rule and I love the premise of your series this time around, I think the unwritten rule is that this is not a profit maximizing industry. It's a revenue maximizing industry. It seems to me almost everyone and I sit through all these board retreats in hospitals and every single one of them has in their top five imperatives, growth and guess what? We grow. The revenue keeps going up. And most other countries operate off of, I would call a balloon in the box model, which is instead of trying to have competition or whatever, they basically put the health system in a box and they sit on the box, right? It's a top down control mechanism. And that's what yields relatively higher performance because it's stamps down the total revenue model.

Ian Morrison: And I think the US is sort of addicted to growth. And the other one I would point to is addicted to self-insured employers, writing a very big check, massively larger than the actual cost of delivering care. I think those are the two sort of fundamental issues that we need to reevaluate.

Robert Pearl: What will stand in the way of change?

Ian Morrison: I think incumbency. I know you teach at Stanford and I live two good three woods away from Stanford and occasionally people will stumble across my resume and call me up some smart, MD, MBA, who's got an idea to disrupt

healthcare. And I always say, "If you're going to disrupt American healthcare, the American healthcare system is larger than the entire Italian economy and about as well organized, right? So if you're going to disrupt healthcare, it's a bit like disrupting Italy, good luck with that." And in fact, it's actually twice the size of the Italian economy and it's the fourth or fifth biggest in the world depending how you measure it. But I think long-winded way of seeing, Robbie, that the thing that prevents us from doing it is incumbency, quite frankly. And we have a lot of institutions who are on this revenue-maintenance track. And it's very hard to disrupt that at the scale that we currently have invested in the American healthcare system. Not that it's all wasteful, but that there is considerable power to that incumbency.

Robert Pearl: I'd like to dive a little deeper into the three themes you talked about in terms of the second curve. And you talk about customers who won't tolerate inefficiencies and lack of convenience and yet patients in healthcare, from my perspective, aren't getting anywhere near what they demand in retail, travel, and finance. Why?

Ian Morrison: I think that's a very key point and the great Kenneth Arrow, economist many, many years ago, 50 odd years ago now, wrote about why healthcare was different. I trained with Bob Evans, the Canadian health economist. And again, he sort of viewed the health system very differently than the traditional way of classic economic theory. And the long-winded way of saying that it's a tough industry because of the asymmetry of information. You're a doctor, you know stuff I don't know as a patient. And therefore, as a transaction, when I'm purchasing health services or I'm seeking health advice, I really have to rely on your agency to help me get through the difficult times. And that tends to be the experience patients have, having been a patient not that long ago, you cease to be sort of a rational "consumer" and become a kind of frightened human where you defer to expertise.

Ian Morrison: And I think that is a fundamental barrier that exists to actually having a more market-like or consumer-responsive health system. But that shouldn't excuse us in healthcare, I think we can do much, much better in deploying the kind of tools that we use to get Uber or DoorDash or organize travel. We need to use those tools and those analogies in the healthcare system and really improve the experience overall.

Robert Pearl: Yeah. Let me go to another area where knowledge asymmetry can't be the answer, you said that technology needs to be faster, cheaper, and better. And yet when I look at healthcare, it's the only industry that I can see over the past two decades with introduction of AI and computers and robots have raised costs without any major improvements in quality. How do you explain that?

Ian Morrison: I think it is the healthcare conundrum and actually I think applies to higher education as well, ironically. And if you look at the things that have gone up at price terms over the last 20 years, hospital prices and college tuition are probably the two outliers compared to stuff like, cheap stuff from China or cell

phones or computers. My new Mac is probably a hundred times more powerful than the Mac I had five years ago. No, you're absolutely right. And it is a conundrum. There's some serious economists like Bill Baumol had sort of explained this as the complexity of delivering those services. But I think that's a bit of an excuse. There is no reason why we couldn't radically improve productivity. If we knock down some of the barriers of things like scope of practice, that you've thought a lot about, Robbie, over the years and working in teams with technological support and AI, I think there is tremendous promise in machine learning as a support system for clinicians, not to replace doctors necessarily, but to enhance their productivity dramatically.

Ian Morrison: Some of the other hands on caregiving things, they are tricky, I mean, it's not going be easy to change diapers in an iPhone, but we can use these tools to improve productivity and increase the sort of responsiveness of the system.

Robert Pearl: Again, I'm going to push a little deeper, Ian. Let's look at telemedicine, simple technology, inexpensive. Yes, there were restrictions on payments and restrictions on interstate, but even when all of those things were still not limiting doctors, the use of technology soars to 70% during the pandemic, I'm not hearing a whole lot of negative quality outcomes or problems that exist. And now it's crashed down below 10% except for mental health services. Why is it so hard to use a modern technology in American healthcare today?

Ian Morrison: Yeah, it's a very important observation and I kind of said, I told you so, I mean, because there were early signals even in the pandemic. I mean, my good friend, Bob Wachter at UCSF said that UCSF did 20 years of innovation in 20 days. And Mayo did and others. Now, Permanente Medicine had been doing this for 50 years, investing in technology and people did pivot dramatically, but I think what you saw, if you put this sort of noble part of the argument, it was that patients actually needed certain things where physical proximity mattered, whether it was, I've heard clinicians and certain specialties say I get way more information by actually seeing the patient and holding, in this case, it was rheumatology about looking at somebody's fingers and joints and so forth, get way more information than I would over a telehealth visit.

Ian Morrison: But I think part of it goes back to what I said earlier that we're in a sort of revenue maximizing mode and revenue comes from doing things to patients beyond just the consultation of a telehealth visit. And I would say, Robbie, that my plea in preaching, I'm not a clinician, but I have been sort of saying if all we do is pave the cow path, in other words, substitute an e-visit or telehealth visit for an in-person visit, all we've done is really save travel time and parking, right? What we really want is productivity enhancers. And I think that requires as you've done in your career kind of rethinking end-to-end clinical processes to be more digital in their mix. And that's easy to say as a futurist, it's hard to do because it really requires rethinking the way in which clinical services are organized and delivered. And I know you've thought deeply about that over the years and I think it takes clinicians with the right technological support to really redesign those delivery models for the future.

Robert Pearl: I love hearing you say that I'll be publishing an article next month at the Harvard Business Review talking about five of those opportunities to redirect and recreate new paths, rather than as you say, paving over the cow path. Let me move on to the third piece that you talked about in your discussion about moving from the first to the second curve. You talk about opportunities that come from overseas from other countries in the world, and yet more than 90% of healthcare is delivered today within 15 miles of a person's house. We have the internet, we have opportunities to learn about expertise available everywhere around the globe and yet with so myopic, how do we explain that? And should we change it?

Ian Morrison: I think that's a very important observation. I mean, I was remarking actually at dinner last night, my brother-in-law introduced me to Jim Morgan who ran Applied Materials for many, many years. And when I was working on The Second Curve book back in the '90s, I interviewed Jim and he said, I felt was a profound quote, which was that anything that can be made will be made in China. Just pointing to in the long run. And he was speaking in the early '90s, in the long run, it would be the manufacturing hub for the planet. And similarly friends of mine at Accenture said, any service that can be delivered over the internet will come from either the Philippines or Russia or India. And certainly we've seen that in many, many industries, if you do battle with Comcast, you're having lovely conversations with people in the Philippines.

Ian Morrison: But the short answer, I think is that somehow healthcare has been immune to globalization. And that really has prevented us from opening up the kind of enhancement of productivity that we've seen in global trade. And I think one of the last thing, I mean, if President Biden's speech, the other night, the one area I would disagree with him on is buying America is going to be cheaper. I don't think that's true. I think buying Americans is going to be more expensive. It might be the right thing to do strategically and for our workforce, but David Ricardo, the economist in the 18th century figured out the comparative advantage of nations. And I actually graduated from Edinburgh, 200 years to the day after Adam Smith went there to write The Wealth of Nations.

Ian Morrison: And we still see each other at alumni meetings, but no, I believe I'm a globalist, I believe in globalization. And I think healthcare has been somewhat immune to it. There really isn't, despite your good friend Dr. Shetty's amazing initiatives, there really is a limited amount of foreign trade and surgery with Americans going abroad. There's some to Thailand and so forth, but not a lot compared to the degree to which our other parts of our lives are globalized.

Robert Pearl: You recently wrote a superb and intriguing article, Ian, on the rules of current healthcare entrepreneurs, and you questioned their assumptions and beliefs. Let me ask you about a few of them and see whether these are rules that will happen or changes that will happen in the rules or whether we'll stay with the old ones. The first one was you said that value-based care is inevitable by which you mean a shift from fee-for-service to some variant of a pay-for-value type approach. Is this a rule that's going to happen or one that's going to be blocked?

Ian Morrison: In the article, what I pointed to was the recurrence of these themes and these assumptions, if you like, which I was urging the readers to challenge, because look and we go back a long way. I mean, I've been preaching and proselytizing about value-based payment for 30 odd years. And yet I'm quite disappointed quite frankly in what some people are calling value-based care is on a path to nowhere. If you actually look at the prevalence of capitation in our hospital system, it's minuscule and recent articles demonstrating that amongst physicians, both specialists and primary care, that there was inadequate and relatively low percentages of physicians who were receiving substantial care. And look, you've dedicated your career to advancing the notion of prepaid group practice as a building block.

Ian Morrison: And I completely agree with that, but if you look across the country, most markets don't have those fully integrated end-to-end prepaid systems. And I think there's resistance still in the value movement or to the value movement because of the addiction that we started with of a revenue maximizing industry, who's looking to employer-based sponsored commercial health insurance rates to sustain those revenue targets.

Robert Pearl: Another one you've talked about is the assumption, I like to think of that as a rule by which, I mean, it is something that will happen that the pandemic effect on digital health is massive and will be permanent. Will it or will it not?

Ian Morrison: I think as we've discussed, the evidence on the ground is that we did make a pivot. It was massive, but it was relatively short term. And we've adjusted to kind of a new normal, and that's why I think the work you're going to share in the Harvard Business Review is so important that we can't lose momentum and just revert back. As you well know, patients see value in this and we've got to just get better at using those digital tools going forward to transform our care processes. So, I think we absolutely need to learn the lessons, but I did feel in my kind of assessment of the emerging facts on the ground, that it wasn't, we weren't going to be at that 70% level of substitution for forever.

Robert Pearl: How about the idea that primary care and prevention will eliminate tertiary care?

Ian Morrison: Yeah. And again, I think about your experience at Kaiser, certainly, the experience around the world where more investment relatively speaking in primary care and prevention yields, I believe is a more efficient and equitable system, but you can't substitute everything and not everything is preventable. And I actually would point to the evidence of Kaiser Permanente has done more than any other organization on the planet to reach out and be focused on primary care and prevention. And yet you still within the Kaiser Permanente system have hospitals and acute care that doesn't, it doesn't banish disease is I guess my point, and there will still be residual amounts of care delivered even though better investment in primary care and prevention as a rule would yield a higher performing health system.

Robert Pearl: When it comes to the fourth one, I'd like to modify what you said a little bit and again, phrase it more as a question, technology, is it a force for good or is a force for evil?

Ian Morrison: My doctoral dissertation actually was a kind of an assault on technological determinism. And my view has always been that technology is neutral. It doesn't have a point of view. It's an amplifier. It's a tool and it could be used for good and it could be used for evil. And it could be used, in my case, I was a urban studies major, a doctoral degree. And what I was arguing is that it doesn't inevitably lead to either centralization or decentralization. It depends what the people who have the power and use the technology want to do with it. And so, I still believe that to be the case, but don't get me wrong. I think that if you look at where the productivity enhancement exists and the potential exists, it has to be going back to Moore's Law and the circuits per chip and the power of these machines getting greater every year and the rise of machine learning and artificial intelligence.

Ian Morrison: We've got to get it right. And we've got to use those tools intelligently, but it's the bright spot and we shouldn't ignore it. We should embrace it and do it right. And I think that's the challenge of the next five years is to really bring the best thinking and the best tools to bear for patients and for caregivers, so that we have a higher performing health system.

Jeremy Corr: So Ian, the average middle class person in America feels very drawn to or downtrodden right now, COVID-19, inflation, the mental health crisis, the shrinking middle class, one of the most difficult things, the average American faces and it feels like it's been treated as an afterthought recently is the increasing costs of healthcare. People pay more and more in premiums for healthcare every year for plans they can't even afford to use, their deductible is more than they can actually afford to pay. This causes many to avoid care until it's too late. Most Americans have lost hope in both political parties and the healthcare system as a whole as being able to create any real innovation that will make amazing healthcare available and affordable to the average citizen that is terrified to use the healthcare they have. Do you have a realistic roadmap to address these issues and a message of hope for these average American citizens who are afraid to use the care they have?

Ian Morrison: Jeremy, I think you're hitting the nail in the head. I mean, if there is one mega trend over the last 40 years, it's been the progressive unaffordability for consumers. I was on the Board of the California Healthcare Foundation and we did a study 20 years ago now, I think where we basically identified that in 1970, if you provided health benefits to a family, it cost about 10% of the minimum wage. Today, it's 150% of the minimum wage. And as you correctly point out, what that leads to in terms of behavior, particularly with the rise of high deductible health plans has been people foregoing care and about a third of Americans claim they do that and it was exacerbated through the pandemic.

Ian Morrison: So your question really is there hope for consumers going forward? I think, the Biden administration has certainly in terms of its stop-gap measures through the American rescue plan has provided some kind of insulation from those costs through the rule changes and payment changes for Medicaid and so forth that were short term, whether they can be made more permanent. But really, all of that, including the whole Obamacare apparatus was really to paper over from the consumer perspective the underlying problem, which is that the actual cost of services is going up. And you can insulate consumers by giving them more subsidy, but is that really the long-term answer?

Ian Morrison: I think the long-term answer of affordability is change the way we do what we do, which is what you and Robbie, I think are trying to do with this series is to draw attention that to fix healthcare, you've got to actually fix the care delivery process going forward. And that just simply throwing more money at the existing infrastructure isn't the right solution.

Robert Pearl: Two last questions. Will Alexa and Siri be the next generation of doctors?

Ian Morrison: I think that we will increasingly have machine learning as a starting point of interacting with the health system. I think we're seeing this in behavioral health because with the shortage of behavioral health workers and clinicians is so dire and the needs are so massive that these technological solutions are becoming prevalent as our first line of care for mental health issues. So, I think yes is the short answer to your question that we will see Alexa and Siri is our first line of defense, which speaks to me to the very great importance of evaluating these technologies carefully with regard to efficacy and effectiveness and be rigorous in, if it's a chat-bot service, let's put the chat bots in a double blamed randomized trial. And as some of the leaders in the behavioral health space have done.

Ian Morrison: So, I do think there is an opportunity there and I am excited to see some of these early stage companies come to full scale and see how much improvement in performance we can have. But as I said, as having been a patient, people are still going to get sick, and they're going to want that laying on of hands by experts and looking in the eye of the clinician, who's going to open your belly or whatever the intervention is. And I do think we've got to honor both sides of this. It's not going to be all about the disruptors, eliminating the incumbents, it's about the incumbents also being honored for the work they do and let's help them with these new tools.

Robert Pearl: As you said, you published The Second Curve in the late 1990s, we're a quarter of a century later, how close are we now to being on that second curve? And if we're not yet there, when will it happen?

Ian Morrison: It's absolutely true because I went back and looked at the healthcare chapter then and I was even though praising all the things you and I believe of prepaid group practice and integration and so forth, I sort of reluctantly concluded then that we were on a kind of phantom second curve. We had all the PowerPoint

slides. We just didn't do it, right? And unfortunately, I think that was accurate. And in the back half of the chapter of what a true second curve would look like, I still believe that's the agenda. It's more attention to social investment and the social determinants of health. It's using technology more creatively, it's targeting care delivery to deliver the most value by honoring primary care over specialty. And it's leveraging the technologies we've been talking about more effectively. That still remains our challenge, I think, going forward.

Ian Morrison: And I just think we need to galvanize our leaders. And the work you do is so incredibly important, Robbie, because what you're doing, I think is trying to lead the market forward to find better solutions that honor those principles and actually deliver healthcare services that are higher quality and lower cost. And that still remains the conundrum we've got to solve for.

Robert Pearl: Ian, I could listen to you all day, the combination of your intelligence and your wit, thank you so much for being our guest on season seven of Fixing Healthcare.

Ian Morrison: It was my pleasure and honor. Good luck with this series.

Jeremy Corr: Robbie, what do you think about what Ian said?

Robert Pearl: Jeremy, I love Ian's model of the second curve. The truth is that American healthcare isn't on it yet. I believe there are both systemic and cultural reasons that this is the case. As an example, people don't receive the same level of service as they demand in other areas of their life because the culture of medicine says the patient's time isn't important. And the majority of people are fearful of questioning their doctors, technology lags, because physicians resist embracing new technology like AI fearing that adhering to an algorithm rather than using their intuition will reduce the status of the physician profession and healthcare isn't global because doctors are convinced that American healthcare is the best in the world despite overwhelming data to the contrary. Until both systemic and cultural change happen, the United States will continue to spend double what other countries do per person on medical care and get quality outcomes that lag the other 12 most industrialized nations in the world.

Jeremy Corr: We hope you enjoyed this podcast and will share it with your friends and colleagues. Please follow Fixing Healthcare on Apple podcast, Spotify, or your favorite podcast platform. If you like the show, please rate at five stars and leave a review. Visit our website@fixinghealthcarepodcast.com and follow us on LinkedIn, Facebook, and Twitter @fixinghcpodcast. Thank you for listening and have a great day.