Fixing Healthcare Episode 6 Transcript:

Interview with Ian Morrison

Jeremy Corr: Hello and welcome to the sixth episode of Fixing Healthcare, with Dr. Robert Pearl and Jeremy Corr. I am one of your hosts, Jeremy Corr. I am also the host of the popular New Books in Medicine podcast. I have with me my co-host, Dr. Robert Pearl. Robert is the former CEO of the Permanente Medical Group, the largest physician group in the United States, responsible for caring for Kaiser Permanente members on both the East and West coast. He is 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 Health Care and Why We're Usually Wrong.

Robert Pearl: Hello everyone and welcome to our monthly podcast, aimed at addressing the failures of the current American healthcare system and finding solutions to make it once again, the best in the world. We are very excited you have chosen to join us in this quest.

Jeremy Corr: For 40 years our nation's political and medical leaders have talked about fixing the American healthcare system, no one has succeeded yet. We need a hero. Our guests are the top leaders and thinkers in healthcare.

Robert Pearl: This show's format is simple. Our guests will have 10 minutes to present a roadmap for fixing American healthcare's biggest problems. Then I will probe deeply, based on my experience as a physician and healthcare CEO. I'll scrutinize the plan, pose questions, challenge our guests and help our listeners separate real solutions from hype. Then Jeremy will dive in from the patient's perspective, ensuring their concerns are addressed, making certain the concepts are clear for listeners and help me to translate any medical jargon we may have used into normal conversational language. Unlike many other healthcare shows, we are not interested in hearing about a pilot project that worked in one location or a new device that a company simply wants to promote, we are searching for truly disruptive change, not just a few minor tweaks.

Jeremy Corr: Our guest today is the healthcare futurist, Ian Morrison. Ian is an internationally known author, consultant in futurist, specializing in long-term forecasting and planning, with particular emphasis on healthcare in the changing business environment. He is the President Emeritus of the Institute for the Future, or IFTF and Chair of IFTF's health advisory panel. He is a founding partner in Strategic Health Perspectives, a joint venture between Harris Interactive and the Harvard School of Public Health, Department of Health Policy and Management. Ian is the author of the bestselling books, Healthcare In The New Millennium: Vision, Values And Leadership, and The Second Curve: Managing The Velocity Of Change. Ian, welcome to the show.

Ian Morrison: Thank you very much for having me.

Robert Pearl: Ian, consider yourself an applicant for the job of leader of American Healthcare. You're being hired due to your experience and reputation as a visionary. You're being hired because after decades of talking about the unaffordability of healthcare coverage and nearly 20 years of lamenting lagging quality, and over 100,000 deaths nationally each year from preventable medical error, our country is ready to make a change. As I told the audience, we're not interested in small incremental fixes or simply tradeoffs among cost, quality and service, instead we believe that disruption is possible and, you, Ian Morison are the right person to make it happen. The deliverables are significant in size and scope, but unless we can achieve this level of improvement we don't believe over the next five to 10 years that the American people will be willing to move forward.

Robert Pearl: We'd like you to provide a plan to achieve the following. One, increase life expectancy in the U.S. From last amongst the 11 most industrialized nations at least to the middle of the pack. Increase quality outcomes as publicly reported by organizations like the National Committee for Quality Assurance , the NCQA, by at least 20%. Decrease cost by 20% on federally reported data. Improve service and convenience by 20% on patient satisfaction surveys and improve professional satisfaction for clinicians by at least 20%. You'll have 10 minutes or so to outline this system of healthcare you believe is capable of achieving all of these outcomes and the steps you will recommend that we take as a nation to get there. Ian, I can't wait to hear your plan.

Ian Morrison: Well, thanks Robbie and thank you for having me. I think it's exciting to be offered a job like this because I've never had a real job in my life, so it would be a breakthrough moment. My mother would be very proud. But let me just say, before I dive in, and I think this is a wonderful thought experiment, but I would say that the starting point I would like to take is that perhaps if we ... certainly I'm a Scottish-Canadian-Californian, right? If you take an international perspective, it may be that the solution set that we strive to describe here might be culturally unavailable to us. I say that because I think all health systems are a function of the values of the culture and we stand alone in the U.S., I think, compared to most of the developed world, in the sense that we have not come to a consensus on universality. I think we're moving in that direction.

Ian Morrison: We don't have the same attitudes on the role of government. We believe more in markets and competition than almost anyone else in healthcare and we're more enamored of new technology than almost any other country. We're extremely resistant to anything that smells like rationing and we're less interested in social solidarity, if you like, than other countries. I think those value differences are really incredibly important and are some of the impediments, I think, to moving forward.

Ian Morrison: Having said that, I take on the challenge and I'll try and briefly describe what I think the best we can do. I'm reminded, even though I'm Scottish, I've spent a bit of time in Ireland and a reminder that the old Irish joke about the American landing at Shannon airport and asking the first Irishman he runs into, "How do I

get to Donegal?" The guy goes, "Well, sir, it would be better if you weren't starting from here."

Ian Morrison: I think that's true in American healthcare, the noble goals you've set out of improving quality and reducing cost, it would be better if we weren't starting from here, in the sense that through historical accident we have a healthcare system that has this weird set of funding mechanisms, including a very large role for self-insured employers, which I think is part of the thing that makes us unique.

Ian Morrison: Having said all that, let me cut to the chase and briefly describe what I think might be a feasible solution set that would get to the goals you talk about. I'll give you a quick description of what I think that solution set might be and then maybe we can dive down into some of the component parts of the five goals, if you like. I think, Robbie, you're going to see this as eerily similar to your own work. I've learned a lot from you over the years and certainly, I think your "Mistreated" book nails many of the principles that would be included in my vision of how to solve the problem. But I think the short version is this.

Ian Morrison: I would say that our best hope moving forward is to migrate American healthcare to a system I would put under the label of "Medicare Advantage for All," which has a couple of components. It tries to reconcile these different values with regard to competition and the role of government, but mandates that everybody is in the system and everyone is covered. I think some of previous guests, like Don Berwick, pointed to this. I think it is potentially politically sellable to develop a system around the concept of Medicare Advantage for All.

Ian Morrison: What that would necessitate is migrating and building on the growth of integrated delivery systems, providing some kind of global budget framework from the top down, setting perhaps targets at the state level for spending not to exceed GDP per capita targets, much as they've done in Massachusetts on a voluntary basis. Preserve as a migratory path, a public option to migrate people from existing programs into a Medicare Advantage for All program. Insist on capitation or at least two-sided risk as the prevalent payment mechanism to these systems. Be prepared to allocate the residual uninsured, if there is such a thing, if we cannot get over the line of individual mandate that is sustainable. I would say that a fallback mechanism is to allocate residual uninsured populations to these integrated systems, perhaps on a lottery basis.

Ian Morrison: Then I think one of the big question marks is to migrate the self-insured employers over time into the system and I think it's important not to shock the system. I know you don't want incremental solutions but I would argue that the biggest challenge we have in American Healthcare is getting from where we are, to a better future. It's that migratory path that's important. I think if we did that, if we really created a system of Medicare Advantage for All, we would go a long way of meeting the kind of performance criteria that you laid out as the challenge for this job.

Ian Morrison:	In terms of life expectancy, it is remarkable how poorly performing we are. I think it's partly our priority setting. We don't do the things that would lift up the bottom of the life expectancy tables, simple things like universal primary care and access to generic drugs that you would think would be a starting point to bring people up from the bottom. The other thing we don't do is a eradicate some of the major causes of early death, like gun violence. There was a disturbing new article came out over the last couple of weeks in the New England Journal (of Medicine), basically showing violence was the leading cause of death amongst children, only behind motor vehicle accidents and yet we don't really do anything about that major factor in premature death.
Ian Morrison:	We have this unbelievable oipiod epidemic, which many people, economists and physicians alike, believe is driven by diseases of despair, having to do with the lost Nirvana of the American Dream. I think there are economic and social policy solutions there that are going to be much more effective than medical care. But I do think the life expectancy issue can be greatly ameliorated by least having healthcare system that covers everybody and takes away the stress of knowing that if you get sick it's not going bankrupt you.
Ian Morrison:	I do think linking to universal coverage as a starting point is an important piece of that life expectancy issue. In terms of quality, I think we have to be rigorous in managing quality without it being a burden on the providers and I think again, it's about priority setting of doing the right things that we know have an impact and try and make them ubiquitous throughout the system. I think it's the inappropriate variation in medical practice that still is one of the sources of poor performance, in terms of quality.
Ian Morrison:	In terms of cost, this is a tricky one because I was always trained that healthcare cost equals healthcare incomes and if you're really serious about reducing cost, you'd have to insist that somebody's income was going to go down. It's not true in total, I mean you can migrate a system so that nobody's income goes down, provided you keep it in line with GDP growth. I think realistically that's the goal we should be trying to attain because I do think there are a lot of unmet medical needs in the system still. That cost one is a tricky one, we can come back to that perhaps in conversation.
Ian Morrison:	I think in terms of service and convenience, it is no doubt that particularly for people who are seriously ill, the system fails in its coordination and performance. I think we pay sort of lip service to the patient centricity but I do think that when you have systems like the system you led at Kaiser, who are under a budget constraint or a capitation constraint or a prepayment constraint, and they have a lot of tools and technologies available to them, they can improve service, they can redesign care delivery so that patients receive better outcomes at lower cost.
Ian Morrison:	Finally, I think on the issue of provider satisfaction there's no doubt, certainly I've done surveys over the years as you have, showing that the majority of doctors feel burned out, feel in some senses, alienated and that their work is

not valued. Perhaps burnout is not the right term, it might be demoralization. I do think that providing systems with control, where the physicians, as you said in your book, lead the organization. I'm not 100% convinced you have to be a doctor but I think it sure helps if you're a clinician leading large organizations. I think trying to encourage colleagues to transform in the name of improving care for patients is a professional motivation and these organizations need to be professionally led with that kind of ethos.

Ian Morrison: Let me stop there and say that in my view, the best we can hope for is sort of Medicare Advantage for All as a framework for payment and coverage and that encourages integrated systems to provide high-quality care under some kind of budget constraint. I think a national conversation on values and priorities needs to be part of that solution set, it can't just be somebody from the top down showing PowerPoint. We actually have to bring the public along in this journey of transformation.

Robert Pearl: Ian, thank you very much for your plan. Medicare Advantage for All is not an approach that any of our other guests in season one have talked about. For listeners who might that be certain what Medicare Advantage is, let me offer the following very brief explanation.

Robert Pearl: Traditional Medicare is a fee-for-service approach that any time a patient sees a physician, the physician submits a bill and it is paid based upon a preset price list. Similarly, every time a patient comes into a hospital, the hospital is reimbursed. The more you do, the more you get paid. The more procedures you do, the more you get paid, the more often you get seen. The more often the physician gets paid, the more often you get hospitalized, than more often a hospital receives reimbursements.

Robert Pearl: Medicare Advantage is completely different. It is a capitated system in which an organization, an integrated delivery system, is paid a set fee per year that is based upon the age of the patients that they take care of, because a 90-year-old requires far more care than a 70 year old. Number two, the overall risk of that population, meaning the diseases that it has. Patients with diabetes need more care than patients who are in good health without diabetes or heart failure or other types of chronic illness.

Robert Pearl: The incentives in Medicare Advantage, as you have outlined are to keep people healthy and that the reimbursement goes up for those who provide superior quality and greater satisfaction and down for those who do procedures unnecessarily because they're not going to get reimbursed, simply based upon the volume that is offered, particularly in the context of value not being created.

Robert Pearl: The question I have for you Ian, though, is how do we get from where we are now to where we need to go? Intrinsic in a Medicare Advantage approach is that you need to right-size the delivery system, often having more primary care than in America today, at a percentage basis, and fewer specialists. Having more centers of excellence and fewer general small hospitals, how do you see us

moving, Ian, from the approach of today, from the quilt-type multiple fabric approach of today to one that is unified in a Medicare Advantage type structure?

Ian Morrison: Right, and I think that's the key to the challenge here is, how do you get from here to there, as the Irish joke lays out. As you know Robbie, I trained in Canada in health policy and health economics and observed firsthand the good and the evil of the Canadian system. One thing I learned in my 30-odd years in healthcare, about relative comparisons with other countries is that when it comes to the cost part, the big difference is not in so much the ... most of the countries get more doctor visits, get more hospital visits. The big difference is price. Price and incomes behind that.

Ian Morrison: As you allude to, the real difference is the actual technical content of care is somewhat different. Most other countries have a much, much higher attention to primary care, compared to the U.S. We're crudely 60:40 specialty to primary, whereas everyone else is 60:40 the other way around. I think over time, you can migrate to a different mix. That's the good news, in the sense, that if you're prepared to lay this path forward you could migrate supply physicians to increase primary care and decrease emphasis on specialty care.

Ian Morrison: The problem I see though however is that we've got ... I spoke to a leading academic medical center a month ago and every leading academic medical center in California is full, on an inpatient basis. We don't have a lot of unused capacity and it's partly for the reasons that we've talked about, which is that we don't prioritize the basic primary care stuff and prevent people from being in hospital in the first place.

Ian Morrison: I think there are some real challenges but I would say that if you change the payment system over time, people can redesign and redeploy assets incrementally to come in line with a system that is more akin to dominance of primary care over specialty care and the kind of relative priorities that might make sense.

Robert Pearl: I know you will remember the congressional battles over the sustainable growth rate, the SGR, and the inability of the Federal government to actually force the healthcare system to limit the increase in cost at the Medicare level to GDP, why do you think it will be different this time?

Ian Morrison: Well I think that's a very good point. I think if you look at the examples where this has been done. Again, if I could draw on international comparisons and I think this is the core of the challenge. One of things that's different about the U.S., compared to other countries, almost every other health system in the world is what I call a balloon in a box system. In other words, if you think about healthcare as a giant balloon, what we tend to do in the U.S. Is squeeze on the balloon in one area and it pops out somewhere else. What they do in other countries is they put the balloon in a box and they sit on the box. Even though it's a fee for service system in Canada for physicians, their budget constraints on

the hospital so that they can't pop out and expend a lot of money. There are also limits on where physicians can do certain things. I think it's more of a top-down constraint. That's true in Germany, it's true in Switzerland. The vehicle for that top-down constraint is different.

Ian Morrison: To get your point, how is it going to be different this time? I would argue that necessity is the mother of invention here and I think you see examples of it. Take Massachusetts, who were the early pioneer of universal coverage, migrated to focus on the cost issue and have had this cost containment commission for the last few years where they're voluntarily monitoring health spending in the state vis a vis state GDP per capita. They set some arbitrary target of three and a half or whatever percent. I was at a meeting of the Massachusetts Health Plan Association, they're all patting themselves on the back. As I pointed out to them though, Massachusetts is probably the highest per capita cost of any known corner of the universe, so it is fine to do budget control from the top down when your budgets are enormous, but I do think we're getting to the point where we're going to have to consider slowing the rate of growth even further just because of the fiscal pressure it puts on the federal budget in the long run. This is not an Obamacare, this is Medicare primarily.

Ian Morrison: The short answer, why is it different this time? Because it has to be, because I believe actually that there's a lot of unmet medical need. We have 80 million Baby Boomers who are going through total body breakdown and deaf and dying and the aging in place simultaneously, and half of them have no money. I don't see how that works out real well unless we radically change the way we pay for healthcare, particularly for older generations and the way we deliver care and services for those folks. I think necessity might be the reason why we finally have to pay attention.

Robert Pearl: Ian, I'm not quite sure what a futurist is, how they differ from being a seer but I'd like to at least use the notion that futurists who don't look to the past are likely to repeat the same mistakes going forward. The accountable care organizations were supposed to do many of things that you describe in these integrated medical group organizations. What we know is that they did increase quality a little bit, but they failed to lower cost, how do you see this being different going forward than what's happened over the past decade?

Ian Morrison: Yeah. No, I think that's a very good point, Robbie. By the way, my definition of futurist is an economist who couldn't handle the calculus. I'm in sweeping generalization business and have been for a very long time. I think it's absolutely appropriate to point to a little bit of humility on the future side. I would say that when the ACOs were framed, I was a little bit skeptical. Let me put a positive spin on it, I thought they were training wheels for capitation is the term I used, they were ways to get someone disorganized, disintegrated systems at least on a path of accountability.

Ian Morrison: I thought the weakness, there were a number of weaknesses but the primary weakness was the fact that there was really no incentive for consumers to change their behavior or be engaged with this transformation. I think your previous guests, David Fineberg and others, I think pointed to the very important notion of transformation not only involving care delivery but engagement with patients. I think that's why ... I came to the U.S. In 1985 and met Alain Enthoven shortly thereafter. Even though I was trained as a single payer advocate, I became increasingly aware that Alain probably was the American who had figured it out the earliest, in terms of what was consistent with American values. That's this notion of managed competition in the sense of consumers should have some choice between or among these integrated delivery systems and there should be some consequences to it. It shouldn't be as you can flip over whenever you want, unless you're prepared to pay for that escape valve, in terms of an added flexibility payment.

Ian Morrison: That's kind of analogous to what the Australians do and some other countries, but I do believe you're absolutely right. If you look objectively at what ACOs have done, they've been underwhelming in their ability to both reduce cost and improve quality, even though probably the preponderance of evidence is they've done a little bit better on quality than on cost. But I always say to the critics, compared to what? Compared to doing nothing? I'm enthusiastic and encouraging of the ACO movement but I do think it needs to be migrated to something that looks a lot more like the Entovian Nirvana, if I can use that term, that Alain once laid out.

Robert Pearl: We certainly know that there is probably 30% of the things that people do add little or no value, in terms of measuring life expectancy, quality of life. We know that there are better ways to do things and worse ways and we don't differentiate that in our payment scheme today. How do you see a national solution addressing the individual physicians, personally seeing the self given right to do whatever he or she believes best, even when the science says they're wrong?

Ian Morrison: I think that is one of the $64,000 questions in healthcare and medicine. I'm not a clinician but I've spent a good deal of my career, probably 10 years in an academic medical center, treading at the heels of department chair of pathology, while I was working on my doctorate as a researcher. I've had exposure through that experience and the work I've down with you and others over the last 25, 30 years, to learn a little bit about the medical mind.

Ian Morrison: I've come to the belief and, by the way, when I started my career, one of the things we did was we were looking at, within the same institution, use of laboratory tests for the same diagnosis. This is in Canada, back generally in the early '80s. There was a threefold variation in the utilization of services within the same institution. You amplify that across states and we know the well traveled data from the Dartmouth Atlas that you alluded to, in terms of massive variation.

Ian Morrison: To cut to the chase, what would you do about it? I believe that the solution here is good data, good science coupled to what I would call, shoulder to shoulder medicine. I've been impressed, whether it be a Kaiser Permanente or you look at Healthcare partners, Bob Margolis's group or you look at large integrated delivery systems like Mayo Clinic or Cleveland Clinic, but when clinicians with good science and good data are confronted with that variation, they can be persuaded, if it's in the right interest of the patient to migrate behavior to something that's higher performing. Now, that's all within the caveat of making sure that the economics of all of that line up. Often, in our current system, the economics don't line up, unnecessary or marginally indicated stance done a high price and our facility is actually the lifeblood of a lot of these institutions who are not at risk financially.

Ian Morrison: I think getting the alignment of payment and values of clinicians is critical but it is not easy. I think this is where we fail in the American context. I don't think you can do that by fiat by the Federal Government. I think it has to be an institutionally, professionally led set of initiatives, but that is supported by a standardized payment system and rules of engagement, so that clinicians are given incentives to consider minimization of variation and maximization of output.

Robert Pearl: The solutions you're describing and the one we asked you to do is a rational approach. The alternative is that major change will come through chaotic disruption, as it has done in almost every other industry. Put on your futurist hat now and look at, is that real change going to come to some kind of organized system as you've described or do you think it will actually come in a much more chaotic, true disruption?

Ian Morrison: I agree with the premise that real transformation of industries tends to come from the outside. I wrote a book more than 25 years ago now, called The Second Curve, which was about changing business generally. It wasn't just about healthcare. At that time, the first curve is the old business, the second curve is the new business that's radically different from the first. The argument I made in 1995 or 96, when the book was published, it was written in 95, published in 96, was that the culmination of three forces, the new technologies like internet, increase in consumerization and globalization, those three forces in combination were going to challenge every industry.

Ian Morrison: Healthcare's been late to that. I do think we're seeing signs and signals of disruption of the classic second curve or disruptive innovation sense that Clayton Christensen talked about. I do think that's happening in healthcare but also, maybe I'm just getting old and cranky, but I also point to these young upstart disruptors, that the American healthcare system is larger than the entire Italian economy and about as well organized. When you say you're going to disrupt healthcare, it's like saying you're going to disrupt Italy, I mean good luck with that. The scale is just mind blowing.

Ian Morrison: Now having said that, as somebody who's tracked the trends in the business for a long time we are seeing a point now with digital technologies, with clinical technologies, with genomic medicine that will probably force the hand of these traditional delivery models that I've sort of bet the farm on in my responses so far. There is no doubt that we are on the cusp of the confluence of these technologies coming together to be real, to be actionable, to be scalable. I think done right and done with the willing cooperation of these existing incumbent delivery systems we could have a very good outcome. In other words, we could harness the power of these disruptors.

Ian Morrison: But I have to say, in the second curve work, I found it very difficult to find successful incumbents who transformed themselves. It's not a very common phenomenon and it's much, much easier to be the upstart, to be the Uber, than it is to be a taxi company trying to struggle to change. I think that may be unfortunately what happens in healthcare, that these disruptors find a way to succeed for themselves but in the process it may not necessarily lead us to the best future.

Ian Morrison: The reason I say that is I think the disruptive forces, on the one hand, are likely in the initial stages to be additive rather than substitute. In other words, that we will be creating a lot of things at the margin which are good and which may help consumers but they're not going to fundamentally alter the way we're doing things in the traditional system. I worry a little bit about that and we could get into that in more detail, about some of the concerns. I'm thinking of specific examples, like retail clinics and telemedicine being additive rather than substitutive, as an example.

Ian Morrison: I found it very difficult to find successful incumbents who transformed themselves. It's not a very common phenomenon and it's much, much easier to be the upstart, to be the Uber, than it is to be a taxi company trying to struggle to change. I think that may be unfortunately what happens in healthcare, that these disruptors find a way to succeed for themselves but in the process it may not necessarily lead us to the best future.

Jeremy Corr: Rural health in America presents a unique set of challenges, such as attracting the right talent, access. In a lot of these areas, you still have many homes that still don't even really have access to true high speed internet. In your plan, how would you improve rural health?

Ian Morrison: Rural health in America is a major issue. We have a big country, there are a lot of states. You go to Kansas and I forget the exact numbers, but something like two-thirds of the hospitals in Kansas are critical access hospitals and they have occupancy of between one and two patients per day, average daily census. There are a lot of institutions and a lot of parts of the country, about 20% of Americans live in so-called rural areas. Big geographies in states like Montana and Nebraska and Kansas and Colorado and Maine, I've spoken and been in all of those states.

Ian Morrison: Here's what I think, I was trained in geography. It was my original discipline and I understand economic base theory. The last thing you want to say to a community hospital that's struggling in rural America is, "We're going to close you down." Because you close that place down, it's the last thing keeping that community going from an economic and cultural and social point of view. It is the lifeblood of the community. I always start, when I'm asked by trustees of rural hospitals, at the Kansas Hospital Association, let's say. People ask me that question, I say, "Let me start by saying, I don't think you should close the hospital, but I think you may have to transform it and repurpose it and redesign it."

Ian Morrison: I think one of the things we need to carve out in a national policy is a different way of paying for rural healthcare. I think Alain Enthoven thought this through 20-odd years ago when he was asked about managed competition. I think what you do is you basically provide a block of money, a capitated payment for a delivery system and require that everybody participate through that regional authority to provide services.

Ian Morrison: That's one model. Another model is to insist that there is a larger system partner, sponsor, parent who is willing to provide telehealth and other kinds of support, so kind of what the Mayo Clinic's done in the upper mid-west. I think there are solutions available but you've got to start by saying to people, "You need to change because what we're doing right now is not working well."

Jeremy Corr: In the current political landscape in America, when healthcare is discussed you have many on the left and far left who reference and even idolize a lot the health systems in places like Scandinavia or Canada. Then on the right and far right, you have the same healthcare systems that are, for lack of a better word, demonized for increased wait times, lack of choice and things like that, and saying a system like that would never work in the United States, especially with how everything already is now. What are your thoughts on those two sides and where does your opinion lie?

Ian Morrison: If you look at U.S. versus other health systems and you mention Scandinavia, Canada, the Benelux countries, Holland, Belgium, and so forth,as different types of models. I have come to believe that every healthcare system in the world sucks in its own unique way. It goes back to where we started talking about value differences, they're all ugly compromises around a trade-off of what I think is a value equation of quality of access and security and benefits, divided by cost. And they all suck. There is no perfect health system.

Ian Morrison: The people on the left are enamored with, whether it be Scandinavia or Canada, the whole single payer. There's a number of threads in that. One is that they like the fact that there is no role for for-profit medicine. They like the fact that everybody's covered and they like the performance profile of the aggregate measures. But they probably wouldn't like the waiting times or the rationing or some of the responsiveness issues.

Ian Morrison: One of my dear friends and former editor of British Medical Journal just had major eye surgery on Christmas Eve and he then let then let them know he's a former editor of the British Medical Journal, he's a doctor. But he was at the most distinguished teaching hospital in London and turned up at seven in the morning. They didn't actually do the procedure until two in the afternoon. He was fine with that, that's how the Brits are. Our national sport is queuing, but I think a lot of Americans would have trouble with it.

Ian Morrison: On the other side, the right wing demonize this. Very few people on the right I think have ever experienced Canadian healthcare. I have family members getting care up there and you'd be hard pressed to notice the difference between Stanford and Vancouver General inside the hospital. It's not a dark satanic mills. They're fancy and they're well equipped, so there are trade-offs in all of these systems and I think the left wing, I would say ... Here's another way to think about it, repeal and replace was a slogan without a real clear policy. I think single payer is a slogan without a real clear policy right now.

Ian Morrison: I try to articulate one version of a future which is Medicare Advantage for All, which is sort of a more nuanced, compromise position. I think that's more politically feasible but I think the problem is if you get into this, everybody in Canada has great healthcare versus everyone in Canada has horrible healthcare, you're missing the point. What do we do in America, given we're Americans? We're not getting rid of all the Americans and replace them with Canadians, although that might be probably the easiest way to get a single payer system.

Robert Pearl: Now I want you to put solely your futurist hat on. It's 10 years from today, tell me what is the American healthcare system?

Ian Morrison: I ran an organization for many years where we did 10-year forecasts for 30 years and is kind of fun to go back. I always reminded my colleagues that ... we had a discipline, which is if you're going to go 10 years forward, ask yourself the question what's different from 10 years ago? We're at start of 2019, what's different since 2009? It's Obamacare, the iPhone and Trump. The question is what's going to be different within a 10 year time horizon?

Ian Morrison: The reality we're going to be dealing with 10 years from now is the absolute peak of the Baby Boom moving through the medical care system. Peak of the baby boom, roughly 1957, so do the math. It's right in that sweet spot of 2029, 2030, when we're at the maximum demographic effect. We will have done one of two things. We will either have anticipated that better and have a system where we use high technology to keep people aging in place with tremendous support, where we've made investments in social determinants of health, where we have a system of universal coverage all the way through, which is sustainable politically and financially because it's done on a bipartisan basis. We will have a built the kind of delivery we design into our ongoing health system that incorporates new technology effectively and swiftly at scale. That's the vision that I hope we have.

Ian Morrison: If we don't get on this quickly, because it takes a long time to build that, if we don't get momentum around this job that we all have a part of or applying for, if we don't go after it then I think we're in a very ugly place where some people at the top end of the income distribution will do just fine but a large swath of Americans will be underserved. We will probably be in a malaise of life expectancy for a very long time, where the widening gap between long life of high quality and those living in despair will widen.

Ian Morrison: I hope it's not that dark scenario and I would believe, Churchill was reputedly gave the quote, although I don't think he actually did of saying, "Americans could be relied upon to do the right thing after exhausting every other alternative." I do actually in that, I'm an optimist at heart and I think the fact that you and other leaders are having these conversations is encouraging to me. I do believe there can be a bipartisan, sustainable long-term agreement that combines the kind of values that Americans have with what we know about how health systems work effectively, so I'm hopeful. I'm still plugging away. I think 10 years from now it will be sorted but it will only be sorted if we get together and have these conversations at scale.

Jeremy Corr: You talked about your 10 year prediction but I'm curious, so what single aspect of change in healthcare are you most excited about in that 10 years and what aspect are you most fearful about?

Ian Morrison: That's a really interesting question. I think we have within our sights, the ability to provide reassurance to all Americans that there is a basic floor below which no American falls. I think, notwithstanding repeal and replace, I really do think the recent elections and the path forward will reaffirm that there is a consensus that everybody should be at least provided the assurance that they will have coverage. I think that's what I still maintain is worth fighting for as a human right, as Don Berwick said in one of your previous podcasts. I still maintain that's what I'm most excited about.

Ian Morrison: What I'm most fearful of is that we will shoot ourselves in the foot, in the sense that our own self-interest and silos of optimizing for whether it be the pharma industry of the hospital industry or physicians or technology companies, that we will fail to seize the opportunity. I think the one of the big differences between the U.S., and other countries, a lot of other countries view healthcare as a service, a bit like fire protection. What I worry about the most is that we fail to see the common good here, that we're all in it together and I think Don Berwick made the same point in a previous podcast. That's the danger is that our silos and our competitiveness and our self-interest dominate to the point where we don't do the right things.

Jeremy Corr: With the rise of high-deductible health plans, insurance premiums and deductibles are continuing to increase and this is especially hard on lower and middle income families, which has caused a rise in the number of medical bankruptcies, do you see any hope of this changing in the next 10 years?

Ian Morrison: Yeah, I do actually. We've done quite a bit of polling on this on both the consumers and employees over the years and i think a lot of dissatisfaction of American healthcare and the frustration of doctors by the way, who have to deal with the consequences of this, has to do with rising out-of-pocket costs. We actually asked doctors, "What drives you nuts?" The government drives them nuts but electronic health records drive them nuts if they're not done right, but high deductible healthcare also drives them crazy because they have to deal with the consequences of that.

Ian Morrison: As you say, it's hurt families and it's hurt physicians. The reason why I'm a little bit hopeful is if you look at the polling of employers, for example, many employers, the majority in surveys we've done, say that they think they may be reaching the limits of cost shifting to their employees and I think that's encouraging that there's an acknowledgement. It doesn't help though, it hasn't stopped them from doing it, let me just say that. We continue to see rising deductibles and copays but I think there is a growing realization that it may be counterproductive. I think when you had David Fineberg on, he was talking about his experience at Geisinger about how to manage the different streams of patients, the heavy utilizers. One of the best ways to eliminate the financial burden those heavy utilizers feel, in terms of accessing their medication.

Ian Morrison: I think the policy folk are getting a better understanding and the payers are getting a better understanding of how skin in the game, to use the colloquial term, could be counterproductive, so that's encouraging. Now, the problem is we all know first-dollar health care coverage is inordinately expensive and that's why I think you have to box this system in with some kind of budget constraint, otherwise you're just asking for trouble.

Jeremy Corr: Well Ian, we have taken up a lot of your time today. Can you please provide a closing statement with takeaways for both industry leaders and for the average healthcare consumer? You may also ask them to follow you on your various social media channels.

Ian Morrison: Okay, Ian Morrison. I'm available on Twitter @seccurve S-E-C-C-U-R-V-E and my web presence is the eponymous website. I've been on the web, one way or another for decades, www.ianmorrison.com.

Ian Morrison: Well, let me just say it's been a real pleasure and I'm delighted to have the opportunity to talk about these issues with you today, and have high regard for you both. I think America is better than the health system we have right now and we can build a future. I've outlined an approach one might call Medicare Advantage for All, which builds on what we know about the benefits of care coordination and integration, in terms of a delivery system that recognizes the importance of having some kind of global budgeting framework that insists on having everyone covered one way or another and that provides payment systems that really reward innovation and outcomes, by providing capitation or two-sided risk, to use a technical term.

Ian Morrison: We need to encourage all actors, including self-insured employers, to move us towards a system that serves patients better by re-engineering the way we deliver care, redesigning care delivery systems within a budget constraint. I think that future is attainable, I think it's politically sustainable on a bipartisan basis and I am confident that if we can convene and encourage stakeholders to get to a point of agreement on both design and principles for that future, it's something that will lead us to a health system 10 years from now that is actually delivering on that promise and is consistent with American values.

Ian Morrison: I often say to people, "You're not Canadian." I'm married to a Canadian. Canadians are different from Americans, they describe themselves unarmed Americans with health insurance. There's a cultural difference. We've got to design a system in America that's right for Americans and so it will have and honor many of the values that we hold, including an appetite for innovation, an appetite for competition, a skepticism about government as the only way to do things. But I do think we have challenges ahead and that if we don't come together to try and focus our attention on redesigning health care for an aging Baby Boom in particular, we're going to regret it. I think the opportunity is now to have those conversations and I appreciate the chance to contribute to it.

Robert Pearl: Ian, thank you again for being on our show today. I love the quote you just said, it's what I will reference many times of the future, that America is better than the health care approach we have today. I also loved your prescient view that if we don't change over the next decade, the impact it's going to have and the human price that will be paid by our country as a consequence. I can't promise that your Medicare for All approach and the recommendations that you've made along with it, will be the ones our nation embraces but for any of our listeners who thought before today that a solution didn't exist, you have proven them wrong. This has been a lot of fun.

Ian Morrison: Thank you Robbie and it's been really a pleasure, and thank you Jeremy for organizing this. I wish you good luck with season two.

Jeremy Corr: Next month we will begin season two of our show, that will offer a totally different format. Our first guest will be the cardiac surgeon, entrepreneur and disruptor, Dr. Devi Shetty. He is chairman and Founder of Narayana Health, a chain of 21 medical centers in India. He has performed over 15,000 heart operations throughout his career. Devi is committed to making healthcare as affordable as possible. Today he provides cardiac surgery for less than $1,800 on a case, compared to over $150,000 in the United States and his results match the best hospitals in the United States.

Jeremy Corr: Recently Dr. Shetty opened a hospital on Grand Cayman island, a beautiful tourist destination and a one hour plane ride from Miami. It is likely to become a high quality, low cost alternative to facilities here in the United States. We are confident you will find his comments and those of the other season two guests provocative. Listeners who are certain the American healthcare system is the best in the world will be very surprised by what they hear.

Robert Pearl: Please subscribe to Fixing Healthcare on iTunes or other podcast software. If you like the show please rate it five stars and leave a review. Visit our website at www.fixinghealthcarepodcast.com. Follow us on LinkedIn and Twitter @fixinghcpodcast, the HC is for healthcare. You can find our personal LinkedIn and Twitter accounts on the website. For additional information or other healthcare topics you can check out my website, robertpearlmd.com. We hope you enjoy this podcast and will tell your friends and colleagues about it. Together we can make American healthcare, once again, the best in the world.

Jeremy Corr: Thank you for listening to Fixing Healthcare with Dr Robert Pearl and Jeremy Corr. Have a great day.