Physician Insurer Magazine E-enhanced Content:  
A Conversation with Ian Morrison

Dana Murphy, Editor of Physician Insurer, and Eric Anderson, Director of Public Relations and Marketing, sat down with 2012 Medical Liability Conference keynote speaker Ian Morrison for a follow-up conversation on his thoughts and insights on the transformation of healthcare—and what it means for doctors and patients.

Murphy: It seems like we have a wonderful healthcare system, priced like a Cadillac. But few Americans can afford it. Where do we go from here?

Morrison: Affordability has become the central issue. In the vast majority of states across the country, the prevailing cost of health insurance exceeds 20% of median income.

So we have a Cadillac healthcare system, and if it keeps going up, where will we end up? My fervent hope is that we can bend the trend—if we can get it to grow at even 1% above GDP per capita, we’d be doing a lot to save us money in the long run.

And there are ways in which this is being done. I think we are redesigning care. But we are not releasing the economic benefit of that yet. A lot of the redesign is more expensive, not less—like investments in information technology, and the acquisition of doctors. Some would argue that the economic power being created by these institutions is overwhelming.

But we are also seeing purchasers use tools like tiered networks that use a “skinnied down” network of providers, who’ve been selected based on cost effectiveness, with strong incentives for consumers to go to those providers.
But I agree with you, I think the real questions is, can we afford to keep going in the direction we’re going, which is spending more of the national wealth—and of employees’ effective income. Americans have not had a wage increase in a decade, because all of it went to healthcare.

Is that the right way to run the store—especially in light of our relative performance on health status?

Murphy: Do hospitals have an incentive to become lean and mean, cost-wise? On the face of it, they don’t seem to.

Morrison: That’s a good point. That’s why many of us believe they have to be brought into risk-sharing arrangements. They have to be put under something like a capitation incentive or global budget incentive, so they make different decisions about care processes, and how they spend their dollars.

More is still better if you’re a fee for service system, whether it’s a bundled payment, DRG, or whatever—more is better.

Anderson: Well, to your point, some administrators are focused on building new wings and adding beds, as opposed to looking at the other side of the equation.

Morrison: When I go to the hospitals, I say, what are you people smoking? If we are trying to reduce costs, why are you expanding capacity? How is that possibly going to work out well?

I think that this is part of what has to be done—to put in place an incentive for hospitals that provides them with a cautionary note saying, look, the premium dollar is the key here. If you have entities that emulate the Kaiser model, where every dollar a doctor saves because he decided something was unnecessary is a dollar that goes to the bottom line, it would be productive.

I don’t mean that hospitals are going to become insurance companies. I don’t think many of them are capable of taking on that risk. But there are partnership opportunities with health plans, where those risk-sharing arrangements can be developed.

Murphy: We speak of “productivity” and “performance” as if medicine were a widget. My question is, how do you bring that sort of metric to a process that people talking, and relating to each other. Already, physicians are feeling tremendous pressure to see a given number of patients each day.

And for the PIAA companies, aren’t there implicit increases in liability risk if someone is doing a sketchy sort of patient workup?

Morrison: I agree. The answer can’t be what I call “hamster care.” I coined this term in the mid-90s to describe doctors on a treadmill in a discounted fee-for-service arrangement having to move faster and faster—to get to their target income by doing more stuff. I don’t think the future of medical care is hamster care. I don’t think it’s about doctors seeing 60 patients a day. That’s how the Japanese do it—with unbelievably short visits that are basically retail opportunities to sell drugs. That to me is crazy.

A lot of what we do in medical care requires an encounter. But a lot of what we do, does not. Seventy-five percent of healthcare cost is for management of chronic illness. What I would rather see is that, in the moments when it’s critical for a clinician to spend with a patient, that’s when there is an encounter.
I say “clinician” because it doesn’t always have to be a doctor. I believe in team-based care. It can be a nurse practitioner—or a customer service rep.

If you look at the systems of care that are high performing—and often, these are low-cost environments—oftentimes it’s the patient who is multiply co-morbid and has difficulties in his life, who gets benefit from having a buddy who listens to his medical problems in a particular way.

**Murphy: Do you have an example in mind?**

Morrison: There is a clinic in Alaska that was looking after an impoverished inner city with a population of Native American people, many with complicated socio-economic backgrounds.

They totally re-engineered the primary care process. Instead of a doctor trying frantically to see more patients, there is one doctor supervising six nurse practitioners and ten customer service reps—people from the community, who actually helped out by asking patients, over the phone, about what wasn’t working out in regard to their health, and how the clinic could fix that.

Now, what’s the liability with this? You could argue that if that care redesign is evidence-based, you have a defense that this outcome is better than hamster care.

Because that is how we’ve done it in other industries. We’ve found a way to leverage competency to do self-service, to do interaction electronically, and mitigate the need for face-to-face.

Look at what Virginia Mason system is doing in Seattle in regard to low back pain. At the urging of providers, they’ve cut down the number of MRIs done enormously. And I don’t think they’re getting sued more.

**Murphy: So there are more market forces that will drive companies now very expensive to become lean and mean?**

Morrison: I think there are, although it’s not easy to take costs down. So I think that instead of budget reductions by large institutions, you’re going to see winners and losers, and consolidation. And I do think that these regional pyramids are going to happen.

**Murphy: What kind of time horizon are you looking at, in seeing this transformation?**

That’s a really important question. I write a regular column, and one of them I called “The Half Life of Healthcare.” These things move at very different rates. But we have a tendency to conflate everything we see in the future—we’re going to be integrated, capitated, countable with IT, and reimbursed on a per-package rather than per-piece rates. We see it all happening at once.

No. They’re moving at different rates. You can buy a doctor group next week. But turning it into a highly functioning, clinically integrated, culturally aligned enterprise takes about 30 years.
Anderson: And you alluded to the trend of the diminishing presence of the independent physician practice. That is certainly a major concern for our members. We saw this in the 90s, with group consolidation—but it went away. Is this going to stick more now, given the fact that there are social shift propositions, for instance, physicians wanting more work-life balance?

Morrison: That’s a great question. In fact, there are differences. One of them is that the stakes are higher, with costs—we’ve hit a wall now. Second, the use of quality metrics and an understanding about what high performance is, coupled with the degree to which they are tied to payment, is going up by the minute.

It’s not going as fast as many of us want, but it’s directionally moving that way. So it’s really hard for a doctor to say, I’m better than X Healthcare, if the data don’t show that. It doesn’t mean that solo practice can’t outperform.

This is why there is a kind of spot market for care. What a lot of purchasers want to do is not deal with these large integrated systems, but instead, unlock the subset of doctors inside those systems who are in the top quartile of performers. Because there is as much variation within a system as there is within systems.

Malpractice is definitely a factor in how doctors are choosing to practice. We did a survey that showed that this is one of the big reasons why doctors want to get under the umbrella of healthcare systems.