[MUSIC PLAYING]

ERIC BRICKER: People who can manage people manage the people who can only manage things, and the people who manage the money manage everything. So this is why I pay attention to health care finance, because the issue becomes, who are the leaders? Not only the leaders of other people, but who are the leaders of how the money is spent?

ALEX MAIERSPERGER: He's taught us all the gap between what we hear about health and how health actually works. Physician, entrepreneur, consultant, educator. I can't think of anyone better in the world to teach us what happens next in the age of AI than Dr. Eric Bricker, founder of AHealthcareZ

When I was doing a master of health care administration, and I think this is probably true about a lot of the programs and a lot of the people that get into health care throughout the years, is you have all sorts of ideas and thoughts about changing the system. And so hey, we're going through this education process one day, we're going to make these big changes.

And some of it's personal stories, it's health care was unaffordable for my family. Some of it's, this is the way we were treated, all the things that can go wrong in a life that-- or cause you to pursue education that way.

But then there's this also idea of-- among a lot of the classmates I had where, I'm going to eventually be a CEO of this hospital system and I'm going to make dramatic changes.

And I think that if you step back just a tiny bit and think about that career path, it's essentially, I'm going to invest 20 years of doing all the things I'm asked to do at the very highest level, then I'm going to get chosen by a board of directors to be this system CEO, and I'm going to go in there and tell them that I want health care to be less expensive, and so we're going to make less money next year than we did the previous year.

So I'm putting you in this role of system hospital CEO. You're a new CEO of a mega system, you have to go in front of the board of directors, you want to make major changes, what are really your options?

Is it fire 30% of administrators and gain efficiency in AI? Direct contract with employers, is there some unique contracting solutions that you can do to keep revenue up and profit margin up? Is it robots? Are there robots involved? Do you pitch them on something? Is it none of the above? So putting you in that mega system hospital CEO seat, what are your options?

ERIC BRICKER: Yeah, so it's a great question. And it is-- it's interesting because the route to change in health care can be, as you described, it can be internal within the existing organizations that tend to be part of the status quo, or it can be an outside organization.

And I think you bring up a very good point, because I don't think it's an either/or, I think it's a both/and. I think you need to have the outside organizations that are typically new and smaller and more nimble create the competition that is necessary to then drive change within those legacy hospital systems or health insurance carriers or what have you.

So typically-- this is just my opinion, of course. Typically you will see hospital systems have some sort of imperative to change when there is a crisis. So unless there's a crisis, then you really aren't going to have the organizational motivation to change.

OK. So fine. So one, I would be in, I would only take the position of the CEO of XYZ hospital system if there was actually some sort of crisis going on. So I'd be like, OK, we got real problems. And they could be-- and it's typical Triple Aim stuff. It could be an access problem, it could be a quality problem, it could be a cost problem, but there is-- but there's a problem. OK, so fine.

Then two, it would be, OK, we don't need to reinvent the wheel. What have other large hospital systems done in times of crisis to transform themselves in a way that better serves patients, better serves the employees, better serves the overall organization from a sustainability standpoint? And I think they're good models for that.

And obviously, Alex used to work at Geisinger, that's a great model. Intermountain is a great model. Ochsner is a great model. UPMC is a great model. There's models all over America. Now, all of those models involve the step of the hospital system taking risk.

And so that can take the form of starting a Medicare Advantage Plan. That can take the form of starting a health plan to offer to employer-sponsored plans. That could involve not creating a plan at all, but instead, partnering-- or rather, contracting with a health insurance company where the health insurance company then collects all the lives and does all the contracting with the Medicare Advantage beneficiaries and with the employers, but then they transfer the risk-- or some of the risk over to the hospital system.

And so the Geisingers and the UPMCs and the Intermountains of the world actually started their own health plans, whereas Ochsner didn't start their own health plan, but rather, partnered with Blue Cross of Louisiana such that they took a lot of risk for their Medicare Advantage population.

So, the last thing I'll add before I get too long-winded, which I probably already have, is, is that, as you can imagine, it's an incremental process. So you don't start it overnight. So you don't flip the switch. It's more like a dimmer. You're turning up the dimmer.

And so when that happens, there does also need to be progress. So people are like, OK, well, it's incremental, but sometimes these incremental things, they don't ever move anywhere. So just like everything, it's kind of like a Goldilocks problem. Not too hot, not too cold, it's somewhere in the middle.

So you don't do this dramatic change overnight with these huge organizations, but there also does need to be progress. So, that's how I would initially answer your question.

ALEX MAIERSPERGER: No, I will not cut you off on an answer at all because I think all of us in the industry, when we watch your videos, the only thing we wish is that there were either more of them or that they lasted longer. And so I feel like I already learned a lot in this first answer.

And it sounds like-- I think there's a lot of health care leaders out there that it does feel we have to do more of what we did last year and just more efficiently or better. It does sound like there's real options to do things differently. Here's the way we have to start in the incremental process of taking on risk, and this is how it changes things for us, and this is how-- so really exciting, really hope people are paying attention, too, if you're in that seat.

It also does sound like there is a health care financial crisis. Not just in our country, but around the globe, you see it of governments strapped for how do we create the resources and the people necessary to be able to treat aging more sick populations than ever before?

And so is there a tipping point to this crisis? I think at least in the United States, we've talked about this year over year of 10%, 20% employer increase for health care costs. Is this just slow boil forever? When you talked about crisis, it sounds like there's a lot of crises on the financial side. Is this-- can health care change be done in a way that isn't massively disruptive to society on the finance front?

ERIC BRICKER: Yeah. So, again, great question, and I'm sure many of the listeners are familiar with the Warren Buffett quote about how health care is the tapeworm of society. What a horrible way to think about it. I don't want to think about it that way.

But the point is, is that it is-- it deals with existential issues of life and death and pain and suffering. Like, I can't breathe. That is-- like, if anyone's ever had that experience, it's incredibly uncomfortable. Run up five flights of stairs super fast and you ask yourself, how do you feel after doing that, it's incredibly unpleasant.

So we live in a world where individuals and physicians and hospital systems and, quote unquote, "societies" as at large could essentially throw an infinite amount of resources at solving these existential problems. Now, the overall problem with that is that then draws resources away from very important things in other aspects of society, like-- you just think of like Maslow's hierarchy of needs.

Whether it's housing or food or education or transportation or having roads, so you could literally have a society where almost all the money is going to health, and the roads are falling apart, and the bridges are collapsing, and everybody is not going to college or has ridiculous debt after college because just all of the resources are being sucked into these existential issues of life and death and pain and suffering. And so-- and now that I've painted that beautiful picture of the future, so what do you do?

So this is where, again, there are pockets of success where this hasn't happened. There are pockets of success where you can-- and I couch all of this-- I think it's the right framework to look at it in terms of the Triple Aim.

There's health care quality, there's access to health care, and there's health care costs. And really, the right way to frame it, I think, is access, quality, and cost. You've got to be able to get in the door, you've got to get good care when you do get in the door, and then it can't-- money doesn't grow on trees. It has to fit within some budget that we can actually spend.

And so, the way that I look at that is in terms of units of disease. And so right now in America-- and in a lot of other health systems in the world, it's a very reactive process where we have these units of disease-- and let's just hypothetically say that I've got coronary arteries-- or coronary artery disease and diabetes, and so I've got two units of disease, and you have emphysema and Crohn's disease, and so you also have two units of disease.

But some people might have zero units disease and other people might have 50 units of disease. And then one person might only have one condition, like breast cancer, but their breast cancer is stage IV, and so just because they have one diagnosis, they might have 50 units of disease.

And so the point is, is that right now in the reactive health care mode that most of the US health care system operates in, when we think about efficiency and we think about spending less on health care, it's typically couched in, how can we spend less money treating the same units of disease or the same units of pathology?

And so that's when you get into, OK, well, we're going to decrease our nursing ratios, we're not going to have as many nurses. And not that-- that's a short-term gain, and everybody, we've already experienced how that then turns into a disaster, about how states that have lower nurse ratios, the care-- the quality goes down, et cetera, et cetera.

So really, the key is, is you need to decrease the number of units of disease. And that's done through primary care and proactive care and not just, quote unquote, "prevention," but treating things earlier in the disease process before they become these gargantuan issues. And that is 100% doable.

Now, the, quote unquote, "adversary" in that relationship is just time. No man or woman lives forever, we are all subject to decay. So then the question becomes, are there ways to decrease-- are there ways to proactively decrease the number of units of disease as a person ages? It's the equivalent to aging well.

And I'm not going to get into that in detail on this podcast, but that is also 100% possible. And there are people that are in-- whether it's the specialty of geriatrics or just the issue of health navigation, where you can actually age well and live the type of life you want to live and actually kind of die the way that you want to die in a way that doesn't necessarily have to create all of these units of disease that have to be reactively cared for in a very expensive way.

And, the last thing I'll say about this-- again, getting long-winded, is I think that can be done in a way that respects the individual patient's autonomy. That-- in other words, it's not about taking care away from people when they want the care, but actually giving them the autonomy to choose what type of care they want.

And just that historically has not happened because the clinicians or the hospital systems or the social workers or whatever, they haven't really described what the care entails, they haven't really gone through the appropriate process of informed consent, et cetera, et cetera.

I had a gastroenterologist tell me one time in medical school, I can get a patient to consent to anything. I mean, because he's like, I can tell them a horror story that will convince you-- and you don't want to do that. That's not really respecting the patient's autonomy.

So again, I've kind of given you a winding, meandering answer, but I actually do-- and listen, and this has happened in places that have aging populations that don't break the budget on health care expenditures like Taiwan and Japan and Singapore. And they don't have to all be in East Asia. There's other places as well all over the world, but it's totally doable. So, I'll pause there.

ALEX MAIERSPERGER: No, I love that. So I've got a few more system questions, and then we'll get into the technology side and some of the other avenues to explore health change. One is on value creation and value extraction.

And so you put out a video about businesses have to strike a balance between those two efforts, and that's essentially what some people think value-based care is, but value-based care often puts those two at conflict.

And you lay out just a very great picture of patients. Some things that are good for patients are not good for the business. And so even when you say value-based care, you need to view value-based care with some skepticism and understand what the trade-offs are.

There was, again, another interview the other day where the person declared the terminology "value-based care" is dead. Is that true? It sounds like what you somewhat described was value-based care in the minds of some people.

And so can you walk through what does value-based care mean in today's context, and is it a term that we should be throwing out to-- putting out to pasture, I think is the term.

ERIC BRICKER: Great question. What in the world does it mean? So first of all-- so at the end of the day, the way that I take value-- what I think value-based care means is the folks that are actually providing the care are taking financial risk, and say-- the old word used to be capitation, but capitation sounds like a bad word. And so they're like, we'll just use a kinder, gentler term of value-based care.

And so that's fine. You can call it capitation, you can call it value-based care. I call it the providers of care-- or the clinicians taking financial risk. That's what I call it. And so then that then brings to issue, then, OK, what is the best way for the provision of care where the providers are taking risk?

And there, my view-- again, none of these ideas are Eric Bricker ideas. I have zero original ideas. All I do is borrow from other people. There's the famous Picasso or Salvador Dali saying great artists artist steal, and like Steve Jobs used that expression at Apple because he didn't create a lot of these things as well, he kind of stole them from other people, so Steve Jobs Stole that idea from other people. And I'm going to steal it from Steve Jobs.

And so that's really the Mayo model, where the Mayo model said, look, the patient comes first, and so the clinicians should not be biased by money in either one way or the other way, so they need to be put on salary because in the traditional fee-for-service model where you get paid for doing more, there's financial bias to do more. The more you do, the more you get paid.

Well, every clinician on the planet knows sometimes you shouldn't do more. Sometimes doing less is better, but not all the time. Then on the clinicians taking risks, financial risk side, well, then potentially it's financially better to do less than you should.

Oh, your bleeding ulcer is fine. Just drink some ginger ale. Well, look, if you've got a bleeding ulcer, ginger ale is not going to help that, I'm sorry. It might be a low-cost way, but it's not going to work.

All right, so, how do you minimize that bias as much as you can? Is you put the clinicians who are actually making the decisions about whether or not to do the surgery, et cetera, et cetera, or prescribe the medication, you put them on salary.

And so that's what-- WW Mayo, the founder of the Mayo Clinic, that's what he realized right after the Civil War. I also believe there's nothing new under the sun. So at the end of the day, the way that people act now, we're the same people as the people in the 1870s and 1880s.

And so we react to the same financial incentives. And so WW Mayo was like, yeah, there are all these doctors out there that are doing more than they should. Back then they bartered for stuff. They're like, me 10 chickens to fix this broken bone, and it's like, oh, they tend to be increasing their prices to 20 chickens, and they tend to be fixing a lot of things that don't need to be fixed just to get more chickens.

And so it is important at the individual clinician level, in my opinion, to have them be on salary. OK, so that's fine. I think that is super important. OK, that's just my opinion.

OK, number two is-- and this is where I was shocked. OK. Like, having people on salary just in general for their jobs is not some-- we do that for police officers. I mean, we don't well, if you arrest more people, you're going to get paid more. Well, wait a minute, that's probably not a good idea.

And then likewise, we don't do the-- be like, well, our prison budget is based upon you, the police officer, and what you do. And so, ah, well we've got to keep the prison budget down, so I'm just not going to arrest as many. Like, we don't operate society that way, and so we shouldn't do that for clinicians as well.

But everybody who has a salary still has a performance review. And I was shocked that when you become a physician, like, you almost have zero performance reviews. I mean, it's shocking. I actually pulled a lot of my friends that I keep in touch with from medical school, and I'm like, do you get performance reviews? And the answer was, about 50-50. About half did and about half didn't.

And even of the half that did, it was just once a year, and it was a very short performance review. And so everybody needs coaching. Like, everybody needs to get better. Like, even a clinician who's been practicing for 20 years, what, they don't need a coach? I mean, everybody has biases. They're blind to their own lack of performance in certain areas.

And listen, performance reviews aren't perfect. I mean, obviously you can do 360 reviews, et cetera, et cetera, even the performance review process can be filled with politics, et cetera, et cetera, but the point is, is that you strive to have accurate performance reviews, as you should.

And that performance review relates to things like productivity and quality and communication and advancing your skills and keeping up your medical knowledge, et cetera, et cetera, but I think in a world where you have salaried physicians who are still under the-- and oh, by the way, like, Mayo does that. And oh, by the way, the hospital system of Mayo is actually run by the clinicians. So the vast majority of Mayo's board is clinicians. The vast majority of Mayo's executives are clinicians.

And the Cleveland Clinic is like, huh-- this is a long time ago, but the Cleveland Clinic was like, huh, we're just going to copy the Mayo Clinic. And so they-- great artists steal. And so the Cleveland Clinic has also become one of these incredible places.

And what's really interesting about both of those places is if you talk to the doctors and the clinicians there, they are also both highly collegial environments where the clinicians cooperate a ton. And I will tell you, in many hospital systems, that does not exist. It's a lot of individual cats doing individual things in parallel, but not necessarily in a teamwork fashion.

And so one of the-- I mean, so here, you're trying to do value-based care, hospitals taking risk, et cetera, et cetera. One of the wonderful side effects of that type of compensation model and performance review model is it creates a tremendous amount of collegiality, which then draws clinicians to--

I mean, at the end of the day, listen, I'm not trying to say bad things about rural Minnesota or Cleveland, but at the end of the day, not a lot of people necessarily want to live there, and they become these huge magnets for excellent physicians because they want to work in that type of collegial environment even though the winter is crazy cold and they have gobs of snow.

So, again, we don't have to reinvent the wheel here. There are absolutely models that have already succeeded. So in my mind, it's not such a question of why aren't the models working, the question is-- because-- and again, this is a Stephen Covey idea, but there's a force field analysis. There's forces for--

So I've just told you all these forces for risk-based care, value-based care, or capitation, or whatever you call it. Those are all the great things for that. And physicians on salary, yada, yada, yada. So then what are the forces against?

And we don't have to tackle that in this conversation, but I think that is actually the reason why it's not happening. It's like if you're trying to go down the highway and you've got your foot on the brake and the gas at the same time, the answer is not necessarily to push down harder on the gas. Sometimes the answer is to take your foot off the brake.

So then the question becomes, what's the brake in this-- what's the brake slowing us down or maintaining the status quo in today's world? And so much of what needs to happen isn't so much about pushing down on the gas as much as it is pulling off the brake.

ALEX MAIERSPERGER: You've made me suspicious of the way my local police force is incentivized because I have been-- I've been pulled over a suspicious amount of times, and I need to check the incentives there. And maybe I need to also learn about the gas pedal and the brake and when to let off of one or the other.

You have a pinned video on AHealthcareZ that says in the United States, it's not a question of if, but when we'll move to a single-payer health care system, and I think it's five ish years old, maybe a little bit older.

It seems like we were-- going through an MHA program, going through the early parts of my career, it seemed like we constantly got hit with both news media, as well as just colleagues at lunch or things, comparing us to Canada's system or to England's NHS.

But you don't really hear that as much anymore as their systems have undergone such strain, and like I said, it's sort of a global challenge now of some of the systems that said, hey, we're able to deliver the access, the quality, the cost. Now are saying bits and pieces of that are really showing strain.

Is there something that's changed in your mindset in the last five years? Is there an alternate path now, some hybrid approach?

So great question. And I can just tell you what I've observed. And, again, I've got my own biases, et cetera, et cetera, but really, the path to a nationalized health plan has-- or single payer, et cetera, et cetera, that is an arc that spans over 100 years.

And again, to your point, I've actually made a video about this on AHealthcareZ where when FDR was president and he started Social Security, he actually wanted to have a nationalized health insurance plan as well.

And he couldn't get both done, and so he just ditched the national health insurance plan idea, and he just-- because he really wanted Social Security. So it's like, OK, fine, if I can only get one through, I'm going to get through Social Security, that's fine.

Then, Harry Truman also wanted to do the same thing. Also, JFK also wanted to do the same thing. And so even when LBJ passed the legislation that created Medicare and Medicaid, that wasn't LBJ's idea and it wasn't new. It had been the priority of Democratic political leaders for a long time.

And then fast forward, believe it or not, then Jimmy Carter also had that idea. And Bill Clinton with Hillarycare also had that idea. And so Obamacare and the ACA passage in 2010 was just the next iteration of evolving this arc.

So just know-- and listen, Senator Harry Reid-- I don't know if you remember him, but he was like the Senate Majority Leader from Nevada or whatever I think during the Obama administration. Like, he just came out and said, look, the ACA is just a step towards single payer. Like, he just admitted it. Like, you can look it up on the internet. Like, there's a newspaper article where he just says that.

And even when Biden was President, it was like, OK, well, we're going to decrease the age of Medicare from 65 to 60. So it's going to be an incrementalist approach, but just know that you have huge swaths of America, 50%, 45%, 55%, whatever the percentage is that is pushing for this.

And we seem to have back and forth every four to eight years between Congress and the President that tends to be in the hands of the Democratic Party.

And so I'm not-- listen-- and you can totally agree with that. I'm not here to say that that is correct or that is incorrect or that's good or that's bad, I'm just saying, that's the overall multi-decade, multi-generation agenda. And I personally don't think that's going to change. So there will always be that force.

Now, will there be forces on the conservative and the Republican side going against that? Like, of course. Who's going to win that? I have no idea, but there is absolutely a force and a constituency that is in favor of it, and they've been in favor of it for decades, and they likely will continue to be in favor for it for decades.

ALEX MAIERSPERGER: Really great history lesson and really great to see. And I love how you've laid out so clearly the forces both on value-based care, on policy, on health care finance. And we'll talk about one of those forces, AI, whether it's a gas pedal or a brake or which one you're pulling off, I think you'll be able to help lay it out there.

But in other industries, everything from retail to manufacturing to electronic components, consumer packaged goods, there's an efficiency gain and productivity when new technology is introduced. Education and health care seem to be the outliers.

They're often called jobs programs versus traditional industries. Will we see the efficiency that other industries have seen and the productivity go up on-- with AI and health care now getting such a foothold? And where will this productivity go?

ERIC BRICKER: Yeah. So great question. The short answer is yes, and it's already happening. And that is that very interestingly, one of-- and this is really a study in technology adoption and behavior change for clinicians where the AI, and whether you're using OpenEvidence or you're using Gemini or OpenAI or what have you, that clinicians have just automatically started using AI for clinical decision support.

Because the compendium of medical knowledge is too large for any one clinician to have that all in their heads. Like, nobody has it. Like, some of them have more than others, some of them have a lot, but nobody has all of it.

And so at the end of the day, when you have a sick patient in front of you, you have this very acute need, to be like, OK, what's going on and what do I do about it?

And so 40% of clinicians have started using OpenEvidence just on their own. So it's like-- it wasn't some sort of top-down initiative. It's like, hm, we seem to have struck a nerve. And what is that nerve? That when clinicians are faced with a decision around diagnosis and treatment plan and prognosis, they don't know.

And that's OK. We need to have the humility to realize-- or we might think we know, but let's double-check. And that's totally OK. I think-- obviously, 40% of clinicians have the humility to realize that that would be helpful.

And clinicians already do this all the time. It's called curbsiding, where you don't really know what's going on with a patient, and you would ask a colleague like, look, this is not a formal consult, but let me tell you about what's going on with Alex.

And I tell you Alex's story, and they're like, oh yeah, that's definitely a situation where you need to anticoagulate them and put in a filter, and then after a year, come back and take the filter out, et cetera, et cetera. I'm like, OK, that's super helpful.

But getting Alex on the phone is like-- it's hard to do and it takes a lot of time, so obviously doing the AI is just like much faster. So you asked about productivity.

So again, Triple Aim, access, quality, and cost. I think at the end of the day, one, it's a quality thing, where they're just like, hey, look, things where I'm not really sure what's going on here, and I can go into AI-- and what's great is that you can even use the AI with images, and so you don't have to with words, describe a rash. Really hard to describe a rash with words.

You can literally put a picture of the rash in the AI and it can help you-- again, it's not perfect, it's not meant to be perfect, but the point is that it's definitely a help. And then-- so fine. So in terms of-- I think you can absolutely get a quality improvement with that.

And what that does, too, is at the end of the day-- I say this a lot, but many of you probably have heard this from me before, but clinicians really need to love their patients, they need to care for them. And so I went to a wedding where the minister at the wedding, in his homily, he said "Love is spelled T-I-M-E."

And so if we can find a way for clinicians to spend more time with patients, listening to them and talking with them, then that is incredible-- or for a proceduralist, more time actually doing the procedure and not documenting it and not spending time on billing-- or not spending time in meetings, et cetera, et cetera.

And so here, there are not-- OK, so how do you spend more time? Well, you could have each clinician just work 24 hours a day, or if they're working eight hours, have them work 10 hours, have them work-- you can have doctors spend more time with patients by just having them work longer, or you can have more clinicians who are doing patient care, and that's obviously the answer that we're already using with advanced practice providers, APPs, whether it's a nurse practitioner or it's a physician's assistant.

And by definition-- and again, this is no dig on nurse practitioners and physicians assistants, is that they have less training. And so they've looked at the number of hours that a physician has to do in medical school and residency and fellowship versus the amount of training that a nurse practitioner or a PA has, and it's just a lot fewer hours. Like, the whole Malcolm Gladwell, like 10,000 hours to get good at something, yada, yada, yada. OK.

But right now, we are using essentially like an F-250 truck of a clinician to haul some groceries. There's some situations where clinically, it's not that complicated. But right now, we're using an F-250 for groceries where it should be used for boulders, boulders of problems, complex vasculitis and autoimmune diseases and cancer. But there's a lot of care that's kind of like hauling the groceries,

In that situation-- and again, not being pejorative at all. Using the NPs and the PAs with AI decision support is awesome. Like, to have them actually be able to spend the time to get the history and do the physical exam and communicate, oftentimes these NPs and PAs are fantastic communicators, and be able to-- but they don't necessarily have as much time in the training.

And so to be able to have the AI assist with the decision support-- and there's-- we have a limited number of residency positions. We have a growing elderly population. Like, we just don't have enough F-250s to take care of everybody. We don't.

It's not a question of if we use NPs and PAs, we have to use NPs and PAs because we don't have enough residency positions to train enough folks.

So you're going to get efficiency, and NPs and PAs make less. Again, I'm not saying that's a bad thing or a good thing. I'm just saying that there's a market for NPs and PAs, and that is for a lower compensation level. But they still have a fantastic life, yada, yada, yada. OK, fine. So that's one way, is by enabling a sort of lower-cost labor source to provide clinical care. So that's one way you're going to be able to do it.

Then the next way in regards to efficiency, again, is efficiency-- in the military, they refer to it as the tail-to-tooth ratio, where the tooth are the actual soldiers and the tail is all of the logistics and support at the Pentagon, et cetera, et cetera. And so health care does have a big tail-to-tooth ratio problem.

But here's the challenge, is that that tail is not going to go away easily because that tail wants and needs a job. And so again, it's only going to happen when there's a crisis. There will only be an application of AI to decrease the tail and shift more resources to the tooth when there is a crisis.

And so at the end of the day, hospital financial strain and creative destruction is necessary. If we are going to have a large-- and everyone's like, well, we've got so many regulations. Yeah, the vast majority of health is free market. It's not, OK, believe me-- it's on a spectrum, blah, blah, blah, but it's like, look, you look at the vast majority of other countries and America, US Health is dramatically less regulated than all of these other places.

So that's fine. If you have less regulation, then you have to have competition. It's either one or the other. You're either going to be like restaurants where there's gobs of competition, or there's going to be-- or it's going to be like a public utility where you have price controls. I mean--

And so health care needs to decide-- because right now we're in this middle road. And so there will be-- there's a crisis right now of K-shaped economy, K-shaped hospital systems. There's lots of hospital systems that are making gobs of money, they're doing great. And there's other hospital systems that have-nots, that are not doing well.

And so if we as a society and as a government say, we don't want those have-nots to fail because we view that as bad, then we, by definition, have to crank up the regulation.

And be like, fine, you don't want those hospitals to fail? Then we will force those failing hospitals through regulation to have a mandated tail-to-tooth ratio. Be like, fine, you don't want to do that? Like, you're required to have twice as many clinicians as you are non-clinicians within your hospital system, and that'll just be a regulatory requirement. It won't be a competitive requirement to be more efficient in your operations, it will be a regulatory requirement.

And so that is something that, of course, people don't want. People within the industry because they want to-- there's incredibly low amounts of competition in American health care, there's very low competition among hospital systems, there's very low competition among health insurance carriers, there's very low competition among pharmacy distribution companies like McKesson. There's very low competition all over health care, so it's fine.

Like, that, then, allows you, through relatively low regulation and relatively low competition, to then drive up your margins, and-- it's referred to as rent seeking. It's essentially extracting value without creating value, that's what rent seeking is. It's not somebody living in an apartment.

So that is going to-- again, that struggle will continue, but I think the challenge in health care is that it's never called that, and there's so many euphemisms, and there's so much spin that all I try to do on AHealthcareZ is like, look, I don't have a solution to health care in America, but in order for any of us to actually create a solution to health care in America, we need to more accurately see what's going on.

And so that's why-- like, my goal with AHealthcareZ is to just call a spade a spade because you cannot come up with the right solution if all you're doing is putting spin and deception on what's actually going on. And so to the extent-- and of course, I'm not perfect, but to the extent that we can accurately describe what's going on, then the probability that we'll actually be able to find the right solutions goes up.

ALEX MAIERSPERGER: You said 40% of physicians have the humility to be able to use AI, to be able to use technology in their decision-making support. Does that put you on record as saying 60% of the physicians do not have that?

ERIC BRICKER: That's just the most recent numbers that are out there. And so the question becomes, OK, well, are they just-- I mean, it's just by survey. Like, are they honestly answering the survey? Like, who knows?

ALEX MAIERSPERGER: Yep.

ERIC BRICKER: I don't know.

ALEX MAIERSPERGER: I want to come back to a few points you made, but I want to get a little bit of your vision first. So one vision laid out there for the future is, like, robots are going to do everything. That's sort of a stated as robots are going to do the most complex surgeries, we're going to trust robots to save us from falls at home and in hospital settings, all the things. So robots everywhere, all day for everything.

Another vision is that health systems, hospitals, health insurers are basically the same as today with a little bit faster, better, more efficient processes and things. And so those are the two sides to the coin. What's your vision? What does health care look like 10, 15, 20 years from now that we get to experience?

ERIC BRICKER: Well, you're not going to my answer. It's largely going to look the same because health care just changes at a glacially slow pace. So ultimately, the vast majority of the way that health is today, that's how it's going to be in the future.

Like, I don't think the trajectory of health care change is going to-- I don't think it's going to accelerate, I don't think it's going to decelerate, I think it's going to be essentially the same.

Now that doesn't-- it's a rather Sisyphean task. I guess I'm a glutton for punishment. Like, that doesn't discourage me from still trying to be involved in it. So it's OK. Whether you're building the pyramids or the Great Wall of China or one of these huge cathedrals in Europe, it's like, yeah, it's going to take more than a lifetime. It's going to take multiple lifetimes.

But we're going to keep plugging away at it. And that doesn't mean-- just because it doesn't happen quickly doesn't mean that I'm not going to be involved in the process. But it's largely going to look the same. And the reason why it's going to largely look the same is because health care is a services business. In other words, it's the business of people by people.

So really, it's very similar to education. And so at the end of the day, is education really that different? Like, no, it's not that-- I mean, it's so funny. Like, the curriculum that my kids have is, like, exactly the same as my curriculum. He's like, what do I expect in sophomore math? It's like exact same sophomore math that I had back in 1992.

And so fine, so it's not going to change because it's a people business delivered by people for people. And people are dramatically resistant to change. People don't like change. Change causes fear. And, OK, so then that becomes the issue of, OK, well what actually enables human change? And the answer to that is leadership.

And so there will be change and pockets of change where there are tremendous leaders. Again, Stephen Covey said that leadership is the enabling art, and we can look back on great leaders that caused social movements to happen, and those social movements didn't happen unless there was a leader.

And again, that-- so if there's-- I've got a gazillion books I could recommend, but one of them is-- it's actually Ray Dalio, this famous-- ran the largest hedge fund in the world, blah, blah, blah sort of guy. It's called *Lessons of History* by Will and Ariel Durant. It's a very short book, it's only about 100 pages.

But Will and Ariel Durant basically studied history from Ancient times up until the 1970s when they passed away. They won the Presidential Medal of Freedom from Gerald Ford. I mean, they were the historians in America, and they wrote all these huge volumes of history, and then they coalesced all those lessons of history into a 100-page book, it's absolutely amazing.

And in that 100-page book, it talks about all the different lessons of history as it relates to religion and economics and politics and family and business, et cetera, et cetera. And one of the areas was the lessons of history in regards to social structure and leadership. And the lessons of history from that book says that, look, history is made by the leaders, and the vast majority of people just follow along.

And people who can manage people who can only manage things, and the people who manage money manage everything. I'm going to say that again. This is from Will and Ariel Durant. People who can manage people manage the people who can only manage things, and the people who manage the money manage everything.

So this is why I pay attention to health care finance, because the issue becomes, who are the leaders, not only the leaders of other people, but who are the leaders of how the money is spent? And you will get change in health care when you have leaders leading the people and leading the money who enable that change.

And so until-- and that will happen in spots. It will happen in towns and cities and states and potentially even at countries, but until that leadership happens, you will not get the change.

ALEX MAIERSPERGER: I have 100 more questions, and I think we could get to 100 more questions, but I would love to end on that because leadership matters, and it sounds like leadership matters more than ever.

You've been the one to call some employers carrier lap dogs. You've exposed the financial trail across PBMs. You've talked about inter-system charges and how the web of finance works.

And so to hear from you of what keeps you optimistic and how you've seen these great ideas and great leadership traits and great leaders that we can steal from to make health care better here in America and around the world is very inspiring.

Dr. Bricker. Thank you for all that you do to educate and to inspire and to lead as a leader yourself in making us have and experience a healthier future. Thank you for being here.

ERIC BRICKER: Thank you, Alex. Thank you, everybody, for listening.

ALEX MAIERSPERGER: Thanks for listening. If you've learned the great leadership lessons here and you have ideas that we can steal, please email us, thehealthpulsepodcast@sas.com. And for more on how health really works, please check out AHealthcareZ and the famous whiteboard lessons from Dr. Eric Bricker. We'll see you next time.

[MUSIC PLAYING]

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