4sight Health Roundup Podcast
Putting a Finger on Healthcare's Biggest Trends
10/23/25

David Burda:
Welcome to the 4sight Health Roundup podcast, 4sight Health's podcast series for healthcare revolutionaries, outcomes matter customers count and value rules. Hello again, everyone. This is Dave Burda, news editor at 4sight Health. It is Thursday, October 23rd. It's been three weeks since our last regular episode, I almost said three weeks since my last confession. And we're still not talking about the Epstein files, but we are gonna talk about Trilliant Health's new report on the big trends facing the health economy with Dave Johnson, founder and CEO, 4sight Health, and Julie Murchinson, partner at Transformation Capital. Hi Dave. Hi, Julie. How you two doing this morning, Dave?

David W. Johnson:
Good to be back in the saddle. Dave, can't wait for today's show. By the way, my use of the word saddle is deliberate in the coming healthcare revolution. Paul and I use the acronym S-A-D-L-E to represent the standard American diet, lifestyle, and environment. We will definitely be discussing this saddle in our analysis of the Trilliant report today. <Laugh>,

Burda:
You love your acronyms, Dave. Oh my goodness. I'll give you that. That's great. Julie, how are you?

Julie Murchinson:
<Laugh>? I'm well. I spent the week at health, or at least a couple days. So I'm, I'm trying to detox from all the AI ification I experienced.

Burda:
<Laugh> trying to unplug. It's hard, right? Yeah. It's hard.

Murchinson:
It's hard.

Burda:
All right. Now, before we talk about Trilliant's new report, let's talk about No King's Day, which was last Saturday. Dave, how did you experience the nationwide protest against the Trump administration?

Johnson:
Well, I had the micro experience. We attended the No Kings protest in very, very Red Holland, Michigan. According to local reports, it was double the size of the first No Kings protest in June. Joyous atmosphere, lots of costumes and good signs. My favorite sign was, was someone in a frog costume saying, "United, we ribbit, divided we croak."

Burda:
<Laugh>. that's, that's great. Thanks Dave. Julie, how about you? What will you remember about the protest?

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Murchinson:
Well, I'll admit that I was at family Weekend for my son. So we didn't protest this year, but he goes to school about an hour from Columbus outside, 10 minutes outside this little town. I mean, it can't be more than like 15,000 people in population called Mount Vernon, Ohio. And they had a rocketing no Kings protest. It was amazing. The whole town center was filled with people, and it's partially due to the fact that there was just an ICE raid on the Mexican restaurant in that town last week. And people are pretty outraged. It's amazing how in the middle of what is a very red place, you know an ICE raid on your neighbors can hit you too.

Burda:
Right.

That's interesting because Dave was in a red area. You were in a red area, and you know, I certainly am, I was out there with my family and several hundred of my closest at the corner of President Street in Roosevelt Road in Wheaton, Illinois; like you said, Dave, the wit and the creativity of people were just off the charts. It was it was rocking too. And it certainly was more fun than firing live artillery shells over I-5 in California. <Laugh>. How, how stupid do you have to be to do that, right? Speaking of bombshells, while we were off, Trilliant Health released its annual report, the big trends shaping the health academy. And there's your transition. This year, Trilliant identified six trends, which it's supported by data throughout its 117 page report. I'm gonna read them off to you, the six trends, not the 117 pages, and you're gonna tell me which one you agree with most and why, and which one you don't and why your goes one. Price, sensitivity and affordability concerns are reshaping demand. Two. Health economy stakeholders are slow to adapt to changing demographic and lifestyle trends. Three. The healthcare delivery system incentivizes specialty care intervention instead of primary care prevention. I think Dave's gonna like that one. Four. Fraud, waste and abuse are pervasive in US healthcare. Okay. Five. The transition to alternative care settings and therapies is accelerating. And six, if industry cannot deliver value for money and employers will not demand it, the government is prepared to force it. What are we talking about? Troops in hospitals there? Dave, which trend do you agree with most, and why? And which one are you not so sure about?

Johnson:
I agree with all of the six trends. In fact, I'm in violent agreement with all of the six trends in this year's report. I'm going to discuss trend number three. The system incentivizes specialty care interventions over primary care preventions. But before I do that, I just wanted to note that Hal Andrews, Trilliants founder and CEO and I are brothers from a different mother on the artificial and perverted character of the US healthcare system. If you throw in Paul Keckley into our mix we become the three amigos. <Laugh> What Hal does is fantastic. On trend number three, the prevalence of specialty care delivery over primary care prevention. My overall assessment is duh, <laugh>. All you gotta do is look around and see evidence of that. But what's fantastic about the TRIT report is the granular detail and analysis that supports a conclusion that we all know to be true. Page after page of findings I'll just tick a few off. Fewer PCPs per capita than other advanced economies; specialty physicians dominate; primary care is insufficient and uneven; subspecialization is widening the gap between primary and specialty care. Incredible pay disparities between specialists and PCPs; almost a three times pay differential between

neurosurgeons and pediatric PCPs; 265,000 a year versus $750,000 a year. And of course, we don't need doctors for sick kids. And the system sickness, forgive the pun, just continues. Retailers exiting primary care to do specialty pharma. Chronic conditions increasing while proven preventative care strategies are neglected. Higher infant and maternal mortality. Most cancer diagnosis are late stage where the cures are harder to achieve and the treatment costs are significantly higher. Most investment going into high cost treatments, novel drugs, CAR-T and so on. I mean, the list just goes on and on. And I gotta say, just listing these major systemic flaws gives me a headache. Hal ends his first principles discussion with this paragraph. It's really a series of rhetorical questions. What is the core goal of a health system? Does spending more on healthcare mean better health? When is health insurance useful? Do hospitals need to be the central hub of clinical care? Should employers be the main source of healthcare coverage? Should society underwrite the cost of poor healthcare that is attributable to poor lifestyle behaviors? Or instead, promote health and incentivize healthy lifestyles? Rather than thinking about what already exists, what is essential? Ah, God, that's just so good. So this is directly to Hal: Revolution, baby. I will jump the barricades with you anytime, anywhere, every day of the week.

Burda:
Great. Great. And I think you just rattled off about eight topics for our show, <laugh>. Each one of those <laugh> we could do,

Johnson:
We could do a Trilliant topic of the week. It would be brilliant.

Burda:
Yeah, that's good stuff. Thanks Dave. Julie, any questions for Dave?

Murchinson:
I'm having this visual of the three of you with capes on jumping barriers. <Laugh>, I don't know that it's really a reality to be honest with you, but it's funny in my head.

Johnson:
Yeah. Geriatric superheroes

Murchinson:
That's exactly right.

Johnson:
Yeah.

Burda:
Yeah. Barricades with a lowercase B, that's for sure. <Laugh>

Johnson:
Only, three inches off the ground.

Burda:
There you go.

Johnson:
But we're jumping!

Murchinson:
Wheelchairs with hot air balloons. Yeah. Yeah. So Dave, I was somewhat struck by, it wasn't exactly a stat, but a stat that behavioral health utilization has surpassed primary care utilization for the first time in 2024. So if BH is now our new front door, how do we redesign the rest of the house? Are there opportunities to do it differently?

Johnson:
So there's a reason behavioral health is going up, and we're, we're really not even meeting the demand. And the fact that they're more behavioral health visits than primary care visits is hard to wrap our heads around. In the gospel of John, Jesus tells his disciples, in my father's house are many rooms in US healthcare. Since you asked about redesigning the house in US healthcare, we need many front doors, and they need to be personalized, connected, and proactive. It's not clear to me that the current system and its incumbents can get us to the promised land. And for that, you need to go back to trend number six in the Trilliant report.

Burda:
Wow. Yeah. Look out for government, right?

Johnson:
Yep.

Burda:
I think that's the lesson there. Thanks, Dave. Okay, Julie, it's your turn. Which one of Trilliant's six trends are you all over, and why? And is there one you're running away from, and if so, why?

Murchinson:
Yeah, so my my favorite really is number five, which is the transition to alternative care settings and therapies.

Burda:
Hmm, okay.

Murchinson:
And how those are accelerating, obviously. So the reason why is because I've been in these conversations with health systems for years now, and I'm watching this happen in waves and, you know, inventory surgery centers, ASCs, were the first wave, but I'm still seeing systems getting into the A SC footprint extension business. I've also seen waves of just, you know, different types of health systems and different geos just to, it's, there's almost like a playbook in

terms of how different geos with different, you know, population dynamics, demographics are getting themselves and frankly, just different margin profiles and when things actually hit them in a way that they need to expand footprint. So it's just been really interesting to watch number five. The way Chilean talks about it is really specific. I think there's so many more things you could talk about. I was fascinated to, you know, see that at ASCs, you know, they performed over 50% of the ASC eligible surgeries in 2024, which means we're now, you know, really getting into ASCs being a dominant place, even more so over hospital outpatient departments. And of course inpatient. So, you know, it, it's real. And while we might still be doing heart transplants internally, so many things that we are now doing in ASCs. And at the same time, you know, I think you guys remember I was talking to a big national system last year who asked me the question, what do you seeing happening with GLP ones in bariatric surgery utilization? I mean, that, that whole switch flipped really quickly. And, you know, you're seeing GLP one utilization increase like hundreds of percentage points in bariatric surgery, volumes flattening to declining really quickly. So I think it's just, you know, hospitals are, and health systems are really seeing the need to, to move in this direction. In addition to a ASCs, we're looking at things like ambulatory infusion centers. You know, IVX is one of the first major businesses in this space, and obviously there's been a ton of cottage, you know, ambulatory infusion out there, but you're now seeing more businesses, more health systems getting into joint ventures and other, you know rev share relationships with those types of organizations. And we're seeing some specification or some sub-segmentation in the infusion model as well, because of course, you know, some are focused on oncology and some are now focused on on other segments. So big trends happening there. What finally hit me was, you know, this whole Chile doesn't talk about this necessarily, but, or at length, but the cell and gene therapy trend, you know, there seems to potentially be some slowdown there due to the administration's, you know, federal funding, <laugh> gymnastics. But we are starting to see businesses in cell and gene therapies that are basically acting like PBMs. So when you start to see…

Johnson:
Huh,

Murchinson:
…PBMs around those types of therapies, and you start to see like an explosion of distribution across ambulatory centers, there's a real market evolving here. And I think health systems see it. And, you know, the smart ones have been in the game for a while and those who are now feeling even more pain or getting into the game one thing I'll say is Trit does touch on this direct to consumer market and what it's done. And, you know, while telehealth has kind of, I guess, settled out a bit at they said roughly 25% of the 18 to 44 age group, this DDC market has exploded. And granted, it's, it's mostly commercial, right? But it's dwarfing the category that we used to think about as telehealth or hybrid care. And it's gone straight to like a complete almost separation of how people look at their healthcare via those models. Like Him's and Hers, Lily Direct, Amazon Clinic, MIDI, Nercs. I mean, you know, people are getting their GLP ones and sexual health support and dermatology support and other kind of low acuity services. Some even like in the ADHD anxiety realm, they're getting care there. And that's separate from what's happening in the rest of their lives. So, I don't know, I'm not so sure I'm seeing health systems get in that game quite as much, but they better watch out 'cause that's happening.

Burda:
Yeah. People are becoming their own doctors and for some that's good and some <laugh> for some, I don't think it's gonna work. So

Murchinson:
Yeah.

Burda:
Yeah. Good stuff. Thanks, Julie. Dave, any questions for Julie?

Johnson: (00:44:21):
Wow, great analysis. Julie I'm still wrapping my head around the PBM parallel to [00:44:30] some of these new treatments really expensive treatments, and we've seen that unfold before.
Speaker 3 (00:44:39):
Yep.
Johnson: (00:44:39):
Yeah.
Johnson:
The Trilliant analysis finds that both care access and rural communities and telehealth visits are decreasing. How is that possible since expanding telehealth service delivery as the VA has proven, is the most effective way to improve real time care access in hard to reach communities? I know this is a rhetorical question, like all the questions that Hal asked but why don't you go to town on it?

Murchinson:
Honestly, if telehealth is the proven bridge to rural care, we are burning the bridge as patients are trying to cross it. I mean, that's just what it feels under to me. You know, we didn't lose telehealth traction because it didn't work. We lost it because of our inertia, our inability to work it into business models. And I'll say, like, I still see every day systems and plans adopting solutions that leverage telehealth. So I just, sometimes I don't believe some of this data, but I do wonder how much of it just sits outside of, you know, something that a Trilliant captures, but I don't know. It's about inertia. Like we built the infrastructure for access and then we failed to rewire the incentives to sustain it. At a certain point, we're not gonna have a choice.

Burda:
It's really interesting because you know, a year ago, I think I had, you know, two or three, maybe four telehealth visits in a row. Now I haven't had one in, you know, over a year, right? Outta sight outta mind, I guess. And like you say, you fall back into old habits. So….

Murchinson:
Although I will say that Dave you're also one medical patient. Our experience, Burda, is that when you now get on the one medical app, or they send you an email to do something in the app, when you go to book an appointment, they almost force you down the virtual path.

Burda:
Really. Okay.

Murchinson:
So Amazon is, whether it's Amazon or, you know, part of one medical's, long-term roadmap, now I feel forced, I have to almost figure out how to get myself back to an in-office set of, you know, visit options. Do you feel that way, Dave?

Johnson:
Yeah, I do. It hasn't bothered me yet. I think a lot of these digital first platforms are, are going that way. But <laugh>, if you really do wanna see somebody sometimes you gotta get creative. I agree with you on that.

Burda:
Yeah. I think the only incentive you know, when I log onto my portal is you have a balance. Do you wanna pay it now? Right? <laugh>, there's your, that's the first message I get, not how you feeling? Right. So there's my incentive. Well, the report ends by asking whether market discipline or structural reform will happen first to save us. I sure hope it's market discipline, right? I think we all do. All right. Let's talk about other big healthcare news that happened this week. Julie, what else happened this week that we should know about?

Murchinson:
Oh, I'm gonna combine two things, actually. Okay. I didn't answer your other question, which is one, any of those six I don't agree with. And number six troubles me a little bit. I don't know how to think about what the government's willing to do, because there's some crazy in there. But I'm not sure the crazy means everybody to just like, blow up the whole system. But what I experienced at health this week was irrational exuberance for CMS interoperability activities and what that's gonna mean to the industry. And I say that because I actually, from sitting down with people like Kristen Valdez from Be Well, and I mean other, like incredible minds and powerhouse people who are part of that thing, it is like they could really be greasing the skids in a very, very important way. And I think they are forcing some things through a highly collaborative approach there that you could feel palpable on the floor of health. Like, it was, it was pretty amazing. But at the same time, I'm, I'm not sure that the crazy's gonna blow up the whole system. We'll see.

Burda:
Yeah. Yeah. I'm a little, little skeptical there. Dave, what's your big story of the week?

Johnson:
Well, nothing in the news, but my friend Michelle Williams, the former dean of the Harvard School of Public Health, who's now at Stanford, has written a new book with a fantastic title. It's called The Cure for Everything, the Struggle for Public Health and a Radical Vision for Human Thriving. It will publish in February. I've read the manuscript and Michelle asked me to write an endorsement, which, which I've done. And I, I will tell you that as I was reading through the manuscript I found myself comparing public health to an intelligence platform that ingests all

kinds of, of data, social data, and then enables the building of apps. And the apps are things like vaccinations that really do promote public health and by contrast clinical care are really point solutions that help individuals but don't have the broader societal benefit. And Michelle makes a really compelling argument that we got away from public health in the 1920s as we embraced medicine, and we've been starving it ever since. And that accounts for much of this underperformance that we've been talking about in the Trilliant Report. So, as I said, the book comes out in February. I, I think it's well worth anyone reading and it's really got me thinking that, that public health is the cure for everything.

Burda:
Yeah. Sounds like a must read. Thanks Dave, and thanks, Julie. That is all the time we have for today. If you'd like to learn more about the topics we discussed on today's show, please visit our website at 4sighthealth.com. You also can subscribe to the roundup on Spotify, apple Podcast, YouTube, or wherever you listen to your favorite podcasts. Don't miss another segment of the best 20 minutes in healthcare. Thanks for listening. I'm Dave Burda for 4sight Health.