David Burda:

Welcome to the 4sight Health Roundup podcast, 4sight Health podcast series for healthcare revolutionaries, outcomes matter customers count and value rules. Hello again, everyone. This is Dave Burda, news editor at 4sight Health. This is a special edition of the Roundup. We're going to be talking about the future of primary care with Dave Johnson, founder and CEO 4sight Health, and our special guest Dr. Robert Pearl, the former CEO of the Permanente Medical Group. Dr. Pearl teaches at both the Stanford University School of Medicine and the Stanford Graduate School of Business. Dr. Pearl also published a book last year entitled Chat, GPT MD, how AI Empowered Patients and Doctors Can Take Back Control of American Medicine. Dr. Pearl, welcome back to the 4sight Health Roundup podcast.

Dr. Robert Pearl:

It's my privilege to be on with you and Dave. Thank you so much for inviting me.

Burda:

The idea for this special episode came from a regular weekly podcast we did in early November on health system executives saying they want to expand their primary care footprint over the next five to seven years. The number one reason they said they wanted to do so was to improve clinical outcomes. Driving patient referrals to specialists was number seven on the list of seven reasons. Now, I'm not saying health system execs are lying, but I do find it hard to believe that referring patients to specialists ranked last on their list. So, Dr. Pearl, we're gonna get your take on that and ask you and Dave a few other questions about the future of primary care. Okay, here it goes. First, Dr. Pearl, when you look at the traditional business model of a health system where does primary care fit in? And what's primary care's traditional role in that system?

Pearl:

You have to start by asking, is this health system paid predominantly on a fee for service basis, or is it paid predominantly on a capitated basis? <Affirmative>. When I was the CEO in Kaiser Permanente, we were capitated and primary care was highly valued. We paid above the marketplace to the specialists in that area because our financial model was driven by keeping people healthy, avoiding complications like heart attack, strokes, kidney failures, and cancers. And primary care played a major role because chronic disease was the origin of 30 to 50% of these life-threatening conditions. In contrast, when you have a healthcare so-called system that is paid on a fee for service basis, the primary reason for recruiting primary care is as a driver of specialty referrals, because those are the patients on whom the system makes a lot of money. In fact, if people are healthy and avoid some of these complications, actually the health system could end up financially being harmed in the fee for service pay for volume methodology.

Burda:

Got it. Dave, what's your thoughts on the outcomes or consequences of primary care fulfilling its traditional role inside the traditional fee for service business model of a health system that Dr. Pearl just described?

David W. Johnson:

Well Dave, you mentioned in your introduction how this particular episode came about, and we did a roundup podcast, you, Julie, and me on a study that came out and said that health systems were doubling down on primary care. Their first reason for doing so was to improve outcomes. And on my good days, I walk a fine line between cynicism and skepticism <laugh>, but I was <laugh>. I, all three of us actually were full-blown cynics on it. And Robbie happened to listen to that podcast. Thank you for being a good good listener, Robbie, and wrote me a, a long message on this topic. And then we had a subsequent conversation. I said, let's get Dave and Burda and and talk about this. So,

Robbie's exactly right. The, the way the health system works is when you got primary care physicians embedded inside the typical health system, they become RVU referral agents. And that's why we've skinnied down the amount of time they spend with, with patients. The whole idea is have them see as many patients as possible, refer them to as many specialists as possible, and increase the volume of higher paying specialty care services, whether or not this is the important point, whether or not they result in, in better outcomes, and certainly not lower costs and better overall customer experience. So that's what we're fighting against is the momentum, the infrastructure, the incentives, all of this that we built into this monstrous, overweighted acute care system that kind of grinds up primary care physicians in the process, particularly those who want to spend more time with their individual patients and keep them healthy and out of the system, as opposed to just becoming a cog in a system that, that generates more specialty care volume. So that's, that's what we're up against.

Burda:

Yeah. Now that we've set the baseline for where we are and why we get the outcomes we get, let's talk about the misfires or miscues of trying to fix that. Dr. Pearl, you mentioned in your note to Dave, that simply replacing primary care physicians with nurse practitioners and physician assistants doesn't work. And can you explain that to us?

Pearl:

First, let me point out that I did not mean by that, that there's anything problematic about the care they provide. It's usually excellent, but it's misdirected because the total dollars that we spend as a health system on primary care is around 5%. <Affirmative>. And if you look at the wage differential, it's relatively small. So maybe you could pick up a quarter point or a half point. Where all the dollars are, are sitting in hospital specialty care and medications. I often say that 80% of the value is added by primary care physicians, but 80% of the cost is added by the

specialists. And, and I base that upon outcomes, by which I mean longevity and health status. So that's why I wrote that to Dave. The solution to the current healthcare system is gonna involve better control of chronic disease, better health, according to the CDC elimination of 30 to 50% of heart attack strokes, kidney failures, and cancers would happen if we could better control these chronic diseases. And it's been estimated that as much as $1.8 trillion could get saved. And to me, that is the real solution to why I believe we need to invest more in primary care, but we need to restructure the care delivery system to accomplish those goals. And that's where I see generative AI supporting both the patient and the provider.

Burda:

Yeah, those are some pretty big numbers in a good transition to my question for Dave. Dave, what about AI as a tool to fix a broken primary care system? You know, instead of throwing more bodies at it, we're throwing more technology at it. What, what are the pros and cons of that?

Johnson:

Well first of all, Robbie's exactly right, that essentially doing the same thing with lower cost personnel you know, to generate more referrals and volume, it's like that Einstein quote. You know, it's the definition insanity, where you do the same thing over and over again and expect different results. So we really should start from the back and work our way forward, which is what are the results we're trying to achieve? And if the results we're trying to achieve are, how do we have a healthier, more productive and happier population by preventing disease wherever we can, managing it more effectively where it does manifest and only in extreme cases resulting to the types of specialty care that are, are so high cost and interventionists. So can the machines help? Absolutely. I mean, the machines are coming. They can do so much of the, the routine mechanical work that human beings do now that they can relieve

burdens. But on top of that, because the large language models and ultimately what happens with robots, the machines are gonna just be able to pick up ever more of the workload so that the human beings one can be better informed in the moment when they're making decisions and guiding patients and coming up with plans for how to manage their overall health and well being. But then also spend more time doing the things that human beings can do better than machines. You know, I know we've seen studies that chatbots are now the best boyfriends and girlfriends, but honestly, at the end of the day, human to human connection. There's no real replacement for it. And so why not let the machines do the work that is burdensome now for, for clinicians and other types of caregivers and free up our human beings to do what human beings are best at. I mean, that's the world we're heading into. And, you know, as they say on Star Trek with the Borg resistance is futile. It's coming. So why not get on board? Let's figure out how to optimize it. Right?

Burda:

Yeah. You, you mentioned Star Trek. This is how my, my mind works. I thought of the Jetsons, right? <Laugh> and even the Jetsons had a real dog. Right? They didn't have a robotic dog Astro. Right. So it gets to that connection you're talking about. In addition to AI that would work. Dr. Pearl, if you could do one thing from a business model perspective to remake primary care, so it produces the outcomes that we want, you know, healthier patients for less cost what would it be?

Pearl:

Sometimes I feel like a broken record, because the first step to improving the healthcare system, no matter which piece you look at, is to change the incentives. You know, Charlie Munger said, tell me your incentives. I'll tell you the outcome. You're going to get a system designed around volume and price is gonna give you higher volume, higher price <affirmative> system designed around keeping people

healthier is going to be and incentivize it. It's going to accomplish those goals. 'cause As soon as you pull that switch, now the position of primary care in the hierarchy of medicine goes up. You know, people often think that the reason primary care is not elevated. And by that I mean looking just what specialties medical students apply for and how desirable those are. They often think it's the salary that drives the hierarchy. No, it's the hierarchy that drives the salary. But the hierarchy is determined by the outcomes that can be achieved inside the economic model of the system. And that's the problem we have right now. Key people healthier and hospitals have less money. Drug companies have less money. Even insurers, you would think that they would be embracing it. But remember, very often they're vertically integrated in ways in which they do better because they have pharmacies, because they have delivery systems sitting there. So that's the one thing that I would do. 'cause As soon as you do that, now management or chronic disease becomes very high on the scale. And who does it better than primary care? No one and keeping people healthy. And now we're starting to talk about lifestyle, diet, exercise, things that have been shown to be three times as important in terms of longevity as the direct medical care that is provided at the end of life. So this, that would be the, the, the primary driver that I would do. And having done that, it's almost like the tent pieces, that once you pull 'em apart with the, like, with the string, with the elastic string, they pop into place. All the other pieces, I believe would follow from that shift in reimbursement methodology.

Burda:

Yeah, that's a good image. Thanks, Dr. Pearl. yeah. Plus hierarchy drives a salary. I'm gonna steal that one. Thank you, <laugh>. Dave, if you could do one thing from a policy perspective to remake primary care so it produces the outcomes that we want, what would it be?

Johnson:

I’m also a huge fan of Charlie Munger. In the second half of Charlie's that, that Robbie didn't mention is, show me a stupid incentive. And I'll show you a stupid outcome. <Laugh>. Well, on that measure, US healthcare is wearing a gigantic dunce cap, right? Because we spend more money per capita than any other advanced economy, and we are sicker and die younger. And honestly, more of the same will lead to more of the same dismal results, right? And, you know, you push this model out further, we'll be spending ever more money on an ever sicker population that is less equal, less productive, less happy. Who wants that for the future of the United States of America? So, Robbie's, right? If we wanna change the way that we deliver care, we have to change the way we pay for it. Simple, full stop, end of discussion. So as long as we continue to pay overweight and pay more for treatment as opposed to health, we're gonna continue to get the results that, and the stupid results that we continue to generate as an industry, as a patient. So competing on health, as Robbie was mentioning, is very different than competing on healthcare. And we need to get those balanced. We need to invest as much or more in keeping people healthy as we do in treating 'em when they're sick or injured. And part of the reason I was so cynical in that podcast that we did the Roundup podcast that we did on health systems doubling down on primary care you know, health systems aren't doing a great job right now on generating the result they should have, which is how do you drive a better health outcome at lower cost with better customer experience when people need acute care treatment? Why in the world would we expect that part of the industry to come up with the solution for how do we keep people healthier? And part of the debate Robbie and I are having back and forth, it's an interesting one, is where do primary care clinicians and those that support them fit into the matrix? There is a role in the healthcare system for primary care, but there's perhaps an even bigger role for the primary care service to be part of a ProHealth agenda of activities and services. But the one thing, if I had to do I'd go to full blown capitation like they had when Robbie was at Kaiser. And that would, nothing would do more than to get the the balance between resource allocation and desired outcomes.

Burda:
And there goes go all those multi-billion dollar campus improvement projects, right?

Johnson:
Yeah, exactly. <Laugh>

Pearl:
If I can interrupt for a second though. Yeah. I wanna make sure there's I'll call it a misconception that a fee for service approach is more profitable than a capitated one. It all depends upon how well you get the outcomes. Because as I said earlier, if you could take $1.8 trillion out of the healthcare system, the first assumption would be, wow, everyone's gonna lose money. But remember, it costs money to provide the care that drives that $1.8 trillion. And so if you don't have to fund the care because the patient didn't have the heart attack or the stroke, or the cancer or the kidney failure, now you have $1.8 trillion that you can start dividing. Some of it can go to providers. I mean, this idea that says, well, if you're working 12 hours, you need to make more money than if you're working six hours. Not necessarily. You can have a hole that you're digging up and filling in and digging up and filling in. And <laugh>, you've accomplished nothing in that process. Yeah. So with $1.8 trillion to split with a third of it going to the patient and a third of it going to the providers, and a third of it going to the government to reduce the deficit, I think that's a much more profitable and better outcome than simply driving up costs. Where your margin right now for a hospital is what, four, 5%?

Johnson:
Yeah. On a good day.

Pearl:

A lot of money to drive to make a small number of dollars. Yeah.

Johnson:

Yeah. You know, Dave, I'm gonna pile on here because Robbie's exactly right. You know, we're pushing above 18% of our economy to pay for these crappy outcomes we get as an overall population. So imagine as the rest of the world is spending more, we start to spend less as a percentage of the overall economy, we will free up enormous resources to pay people more money to invest in more productive industries to fund vital societal needs. Our healthcare system over the last 50 years has stolen resources from other parts of the economy to pay for its excesses. It's time for healthcare to start giving back. And Robbie, I actually wanted to clarify one thing on fee for service. I think fee for service can be a perfectly rational way to pay for services when you have level field competition and there's comparisons and we know kind of who does it well, who drives the best outcome at the lowest cost with the best customer experience. So there are parts of the healthcare system that lend themselves fee for service. But what happens is we get too much activity. Fee for service is okay if the amount of activity is the right amount of activity. And that's where you get back to, you know, a capitated environment where we're trying to drive overall health outcomes. And that becomes a break on how much of the activity, unnecessary activity or how we eliminate unnecessary activity. So both fee for service and capitation and lower costs are gonna be good for the country as a whole.

Pearl:

Yeah.

Burda:

Yeah. A lot of expensive toys. Right.

Pearl:

I agree, Dave, that once you decide that someone needs a procedure, you should find the best center of excellence and pay them on a fee for service basis. Yeah. And what you can find is that assuming you can drive up the volume because you're setting the patient there, 'cause the quality is the highest, now you can lower your cost on a unit basis and come out way ahead. So it's not that I don't believe that fee for service has a role to play, but when it comes to the overall health system, particularly when it comes to primary care, I'll say, as being the foundation of that system, that's where I think we need to make sure we pay capitation. But yes, once someone needs to have a total joint, replaced the hip replaced, find the center of excellence that does it with the lowest complications and the best long-term functional result, and pay them a set fee that you've negotiated, you can call that fee for service. You can call it a bundled payment. But that is where I think you're absolutely right, that fee for service has a major role to play in American medicine.

Burda:

Let's see if you guys agree on this last question, and it's the same question for both of you. And we'll start with Dr. Pearl. You know, if we do a podcast on primary care five years from now, are we going to be talking about the same thing or something different?

Pearl:

I fear that we'll be talking about the same thing.

Burda:

Ooh, okay.

Pearl:

'cause the incentives are so aligned for the current incumbents that I think they're not gonna be willing or able to make the leap forward. And

I think that that's where generative AI will play such a crucial role. But unfortunately it won't be driven by the clinicians, but driven by someone else who's looking to use it to replace them. So, no, I'm not very optimistic, Dave, because I haven't seen any movement scores pay for value over, I dunno, 20 years that we've been talking about it <laugh>. So, okay. I think most likely it's gonna be an echo of today, but I hope I'm wrong.

Burda:

Okay. Dave, how about you? Same conversation, different conversation?

Johnson:

Well, I'm probably a little more optimistic than Robbie <laugh>, which is interesting given how cynical I generally am. I think what's happened with the healthcare industry is that they've given up the various component parts have given up control of their destiny. And the transformation that's coming is, is much more outside in than inside out. You know, for example, the Trump administration forcing full data interoperability on the entire system that should happen next year completely changes the economics of, let's say, Epic, which has operated with a walled garden and prevented data from flowing where it needs to be. I also think the, and this is Robbie's area far more than mine, but the rate of transformation that's occurring in AI and synthetic biology leads me to believe that we'll come up with new business models where things like angioplasty in five years could be done by machines. And today we overpay highly trained people, essentially to become surgical mechanics. If you wanna see it, there's evidence all around of transformation and the system beginning to crack. So I think we're gonna see more change in the next five years than we've seen in the last a hundred years.

Burda:

Yeah. if the price of GLP ones keeps dropping, I think you're gonna be right.

Johnson:
And it will.

Burda:
Yeah. And it will. Yeah. Market's taken over there. That's great. Well, thanks Dave, and thank you Dr. Pearl for joining us today.

Pearl:
I really enjoy, Dave, your perspectives, because I think you take the complex areas and shrink it down. I think you're pointing out very important pieces about the evolution and the outside to inside. You've hit it on the head. The question that I would pose to you, Dave…

Johnson:
Yeah.

Pearl:
Is in that process, will clinicians and the work they do and the status they have get elevated or will they become subservient to the entrepreneurial companies, to the administrative folks?

Johnson:
Yeah.

Pearl:
…the other individuals in the process? And will that be good or bad for the patient?

Johnson:
Yeah. I, I think overall medical professionals will, will lose status. You know, an irony of the American system is that prior to say the early 19

hundreds, being a doctor was a very low status profession. They, they didn't get paid very well. They had to make house calls. People hated the idea of going into hospitals. And then as the profession saw some real improvements. You know, basically by the twenties we'd closed two thirds of medical schools doctors needed to be licensed. We started to see real improvements in, in research and, and products. And, and basically that made the U-S-C-N-V of the world. But in the process, and this is what Paul Starr talks about in in his, his book the Social Transformation of Medicine from the 1980s still is irrelevant today. And that won the Pulitzer Prize is when that shift happened. We put doctors on such a pedestal that we gave them control of hospital operations without responsibility for building the hospitals or running them profitably. And, you know, fast forward now a hundred years with that model, there obviously been some changes. But we still are sort of disproportionately rewarding physicians for work that's actually detrimental to society as a whole. So to me we're gonna have to rework everything. I mean, disruption is disruption. What comes out of it, I think is is a smaller healthcare system that's much more customer centric has much more use of lesser credentialed professionals and the machines to achieve better outcomes at lower costs. So I guess that's a, a long answer to your question, but I think part of what has to happen is the status and role of physicians and society specialists needs to diminish.

Burda:

We'll see if we end up trusting big tech with our health, right? I'm not sure sure I'm there yet.

Johnson:

My aura ring tells me I was exceptionally ready for the day today, so… there you go.

Burda:

<Laugh>. Well, I got two smiley faces on my CPAP machine this morning. <Laugh>. So there you go. How about, how about you Dr. Pearl? What did tech tell you today about your health?

Pearl:

It told me that I ran well and that my heart rate was improved, but it said I needed to have a little bit more weight lifting, weight training. So that will be this afternoon. And then by tomorrow, hopefully I'll be back into full homeostasis. <Laugh>,

Johnson:

The machines are definitely coming. They're coming.

Burda:

Keeping us all healthy. And great job guys. I appreciate it. And 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 or a little more in healthcare. Thanks for listening. I'm Dave Burda for 4sight Health.