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, February 19th. The Trump Administration wants everyone to stop talking about the Epstein files. We haven't, and we won't start now, but we will talk about the Trump economy, or as some are calling it the healthcare economy with Dave Johnson, founder and CEO 4sight Health, and Julie Murchinson, partner at Transformation Capital. Hi, Dave. Hi, Julie. How are you two doing this morning, Dave?

David W. Johnson:

Well, you recall last week, I gave the harrowing tale of how we got the kidney offer and scrambled to pack up and come to Chicago. And right after today's program, I'm gonna do a day trip back to Michigan to bring back all the stuff we forgot to bring <laugh>. It's amazing when you pack that quickly, how stupid you are in some ways. But anyway, that's my day.

Burda:

Yeah, yeah. You got a lot of, a lot of plates spinning, right? So….

Johnson:

And I gotta get home in time to, to prepare dinner 'cause I'm a full-time caregiver right now.

Burda:

All right. Good for you.

Julie Murchinson:

Go, Dave.

Burda:
Julie, how are you?

Murchinson:
I've had enough curling. That's pretty much how I am. <Laugh>.

Burda:
Do not touch the stone.

Murchinson:
Yeah, I'm done with the curling. <Laugh>. <laugh>. Moving on.

Burda:
All right. Now, before we talk about the economy thanks to the latest jobs figures from the Bureau of Labor Statistics, let's talk about plagiarism. Yes. Plagiarism today is national prevent plagiarism day <laugh>. We all do.

Johnson:
How are we doing? How are we doing on that front?

Burda:
I think we do pretty well, so we'll, we'll find out. So you know, we all do a lot of writing outside this weekly podcast. You know, Dave, you're the most prolific among us three. Has someone ever plagiarized you? And if so, how'd you handle it?

Johnson:

Well, you know, my my proudest moments are when my own words come back to me in a public form as someone else's thinking. I live for those moments. This wasn't writing, but early on in my investment banking career, I came up with this formula for calculating health system debt capacity that was a weighted average of, of various capital statistics related to profitability, leverage, cashflow, that kind of thing. At the time I was working for Bear Stearns, may they rest in peace. And one of the, the, I think the top investment bank healthcare investment bank was first Boston. And someone sent me a copy of one of their presentations, and they totally ripped off my weighted average debt capacity, <laugh> <laugh>. And so, so I went to my boss and said, what can we do about this? And he said, nothing, which just goes to prove that in investment banking, there really is no honor among thieves,

Burda:

<Laugh>. Oh, that, that's a great story. Julie, how about you? Has anyone ever copied your original prose word for word?

Murchinson:

Well, not that I know of, but I will say that, you know, after some years building Health Evolution, I did start to see some people rip off just the branding that we had put together. And, you know, I don't, it's not plagiarism, but it's kind of bittersweet, Dave, don't you think? Like you,

Johnson:

Yeah, yeah.

Murchinson:

It's really nice to see someone appreciate your way of thinking about the world, but it's like copycatting

Johnson:

Imitation is the sincerest form of flattering.

Murchinson:
Yeah, I guess so.

Burda:
I can't recall anyone plagiarizing things that I've written. But, like you, I've had a lot of original article ideas stolen over the years without any credit. So I guess I should be flattered. I did supervise a few reporters over the years who love to cut and paste things from other sources, including some of their old articles and string the pieces together in what they claimed was an original. And we always caught them because they were too lazy to change the type fonts from what they borrowed. So <laugh>, you'd call up their article on the screen, and it would look like the Rosetta Stone, you know, three or four different sections of types. It's a good thing we didn't have AI back then. Who knows what kind of trouble we'd be in. Well, what kind of trouble is our economy in, thanks to the latest jobs, figures from BLS, and there's your transition. The Bureau of Labor Statistics released its latest employment figures on February 11th. I'm gonna share some of the more interesting stats and get your reaction. Here goes, the economy added 130,000 jobs in January, compared with December. Of those new jobs, 82,000 or 63% came from the healthcare sector. In other words, if it wasn't for healthcare, we would've gained only 48,000 jobs last month. Looking at all of 2025, the economy added just 229,000 jobs from January, 2025 through December, 2025. By comparison, healthcare alone added 355,000 jobs. That's nearly 30,000 new healthcare jobs a month last year. In other words, if it wasn't for healthcare, the economy would've lost 126,000 jobs last year. Why? That's not a bigger story. I don't know. Hopefully somebody will steal that idea. Dave, I want you to go big picture on me. I know you took a few economics classes right? I mean, is

Johnson:

Yeah. Yeah.

Burda:

What's the good and bad now and in the future of our academic growth? So dependent on healthcare, and what's the good and bad for healthcare itself?

Johnson:

Well, you know I love these types of somber articles that treat healthcare as if it's a normal industry. And the biggest issues in healthcare, really, in terms of how it affects the overall economy, relate to productivity. Just because a person or company do something doesn't mean they do it well. And my example of that is suppose you're in the business of digging holes and then filling them back up with rocks, right? And you get really good at it. You hire consultants, you figure out what exactly are the best rocks, and you, you put 'em in there, and you can do it really quickly. But at the end of the day, what have you done? You've dug a, dug a hole and filled it back up with rocks. You haven't added anything. So this is where productivity comes into play. If you go to the Bureau of Labor Statistics, they, I haven't done this in a while I assume it's still there, although… What can you assume about the Trump administration? But there's a little video that explains productivity, and they've got a woman named Beth who builds bird houses, and she can build one bird house an hour, but she figures out how to build two bird houses in an in an hour. So what does that mean from a labor productivity point of view, she can either make twice as much money, right? Because she's building twice as many bird houses, or she can work half as much. So the whole key to the US economy from its beginning is our ability to do things better, faster, cheaper, and to the extent we're more productive, we create wealth and, increase income and

good things follow from that. Overall, the US economy has been in a pretty major productivity slump for the last 25 years. It's averaged about one point half percent a year. The exception, by the way, was 2023 when productivity went up almost 3%. Thank you Biden economics. But during that time, the last 25 years productivity and healthcare has been flat to negative. So in essence, healthcare as an industry has been a negative drag on the overall economy. If we'd had the same or greater level of productivity improvement in healthcare, imagine what our overall economy would be doing, how much wealth we'd be creating, how much more income people could take home in their pockets. But it's actually a drag on the economy. So our being so dependent on a non-productive industry as a nation is is problematic. I guess the good news is that if we can figure out how to make the industry more productive while other nations are spending more on healthcare as a percentage of their economy, we can spend less. And the numbers are so large that if we can drop the percent of our economy, we dedicate to healthcare from 18% to 15%, for example, we would add trillions of dollars free up trillions of dollars to pay people more money to invest in more productive industries to fund vital societal needs. Up to this point, healthcare has been stealing from the rest of American society. Imagine a world where we can actually, we as an industry can contribute to greater productivity in the country. And the reason the industry isn't productive, it’s all tied up in the payment incentives and the capture by special interest and so on that, you know. I told everybody about Terry's kidney transplant last week, which is just a remarkable story. She could have come home in two days. She actually came home in three, but that operation 50 years ago, you would've spent three weeks in the hospital. So why does it cost more on an inflation adjusted basis when we're, you know, in the hospital, one 10th the amount of time. So we have a way to go to improve productivity in the economy, in the healthcare economy. And to the extent we do it, we benefit the entire country. So productivity, now, productivity forever.

Burda:

Yeah. More isn't necessarily better. Right? That's my takeaway. Exactly. Thanks Dave. Julie, any questions for Dave?

Murchinson:

Dave, one of the best lines I read <laugh> in prep for this was the healthcare job growth is keeping the US labor force from looking sick. <Laugh>, it was a good pun, <laugh>. So productivity, I was gonna ask you a question about that. So talk to me a little bit about maybe a more specific example of what you're talking about.

Johnson:

Yeah. Well, in manufacturing there's this ratio that they sometimes talk about called production capacity. And it's pretty simple. They're 168 hours in a week, and if you've got an assembly line production capacity measures, what percentage of those 168 hours is the manufacturing line up and running? And a good score is in the high 80%, or even low 90% range. There's always gonna be time to do maintenance on the line, shift, shift changes, that kind of thing. So I was thinking about that concept with relation to ORs operating rooms in, in healthcare, really expensive to build. But at a typical hospital in the United States the ORs run one shift a day Monday to Thursday and half a shift on Friday, and they're dark all the other times. So a good production capacity ratio for operating rooms would be 25%. I can't think of another capital intensive industry that uses its assets in such a limited fashion. So when people come to me and say, we've got, you know, capacity issues or access issues, I just call nonsense on it and say, you know, run your ORs on Saturday or run 'em two shifts a day. Part of what brought me to this realization when I was on the board of a health system in India several years ago most arrogant physicians you could ever imagine, specialist, but we'd be sitting in the board meetings and they'd be sweating over the the income statement and the balance sheet. And the reason was they

were on the hook for funding the funding the construction of the hospitals. [madocta] was the name of the system, and they're now up to, I think, seven or eight hospitals across the country, all over India. And they were the ones that had to run it profitably. So they were paying attention to the details. In this country, we've essentially given physicians control of our hospitals without having the responsibility for either funding them or running them efficiently. And then we've got all these payment mechanisms to screw things up as well. So in India, where you had normal market function and incentives seemed to work the right way, by and large the hospitals, [madocta] hospitals ran two shifts a day, seven days a week, they ran those assets hard. We just don't do it here, and we don't do it here for all the wrong reasons.

Burda:

You missed your calling Dave, as a workplace engineer. <laugh>

Burda:

Thanks, Dave. Julie, I want you to go micro on me rather than macro. You know, if I'm running a healthcare provider or payer organization, and I see these numbers, what am I thinking in terms of my business model? Or if I'm running a healthcare tech or service company, what am I thinking in terms of my business model?

Murchinson:

Well, for providers, maybe more so than payers, but really both labor is my business model. And this report, you know, raises risks and opportunities. Honestly, it, you know, like David, I agree, like, it effectively says that if we're gonna absorb workers at rising wages, that the sustainability of our business models in healthcare you know, have to be less about hiring more people and more about redesigning where and how we can deliver care and get the value out of every scarce resource we have. So it's kind of hardening these facts around labor

costs and outpatient shifts, you know, kind of moving from the forecasting of all that to realizing, okay, this is happening and my model has to change around them. And if I'm a provider specifically, you know, healthcare is driving now most new jobs in ambulatory home health and nursing residential, I believe. And that validates shifts that I'm seeing all around me. So I'd be doubling down <laugh> on outpatient and home-based models, and like really looking at my hospitals only for the higher acuity care and, you know, redesigning care. So every clinician covers more patients through the things we've talked about for years, right? Virtual team-based care automation. And like, you can't endlessly add FTEs. And I'd also have to look at just where am I spending, you know, the most, where am I most labor heavy in my service lines, and how do I lean in to low, you know, the higher margin service lines and the ones where I can leverage staff better. So, you know. Automation is screaming from these pages. Even though that's not what anyone's talking about in this report for payers, the provider wage inflation will continue to push up unit prices, right? So I'd wanna actually lean more in divide based contracts and, you know, kind of total cost of care models and less into making more fee for service, you know, rate increases, like now is the time to change this model. So payers have an opportunity, you know, to take advantage of this. And I'd also say because the workforce is shifting into outpatient my network is a payer and benefit design, and my side of care strategies have to favor ambulatory home and virtual options. Payers and providers could align a lot around that. If I'm a health tech company or some sort of novel service company I'd be paying attention to the fact that we may be actually moving from this phase. We've been in for the last, I don't know, two to three, four years maybe, of all the purchasers who are really focused on revenue. Like, if you just like, really zoom out a decade ago, if I was a hospital, CIOI was focused on digitization for fun, <laugh>, it was, you know, I got paid to put an EHR in and it was, it was fun to talk about, but no one was really putting a lot of pressure on it, right? And then all of a sudden it became about revenue in the last three

to four years, it's been, I've just gotta boost revenue, and if you can't find me revenue in the next year, like, I'm not gonna buy your thing. And this may be a sign that we're finally moving towards, you know, the importance of the bottom line. And a large number of tech companies, I am sure would look at this as validating their thesis that providers and payers will pay for anything that turns labor from a constraint into leverage. Like, we may be actually getting to efficiency, you know, as a value prop, which is not where we've been, by the way, in the last three to four years. So if I'm a tech company, I'd be selling labor leverage, not software. Like we're not just an app in your stack, right? We're your capacity partner <laugh>. So I'd be looking at how to really lean into that positioning, like sell solutions that are about, Dave, what you said. Sell capacity using the same headcount through my automation solution, my workflow tools, my virtual services, whatever it is models that reduce FTEs per unit. And frankly, it's gonna be helpful if these solutions can be operating expense neutral or even reducing within year one, just like they've been demanding revenue in year one. You know? Second, I would anchor, like, again, on those sites of care, ambulatory home, et cetera, build products for outpatient clinics, urgent care, ASCs, home health, s, nfs not just hospitals, because sales will become increasingly important. And I don't know, I think the, the revenue model is always <laugh>, it's kind of a moving target in terms of what purchasers are looking for, but I do think that we're no longer selling maybe the traditional SaaS, you know, software line item and looking at how we're pricing more on a contingency basis, pricing per encounter, per member, per bed, something that's a little bit more usage oriented and, you know, similar to like a contingency model, putting some sort of shared savings or gain share on the line for what your solution could do. So there's a lot of opportunity.

Burda:

Yeah. Yeah. Get efficiency in that value prop and put yourself at risk for it. So that’s great. Thanks Julie. Dave, any questions for Julie?

Johnson:

This whole concept of doing more with less is not something healthcare is very good at. But that's essentially what you're talking about and what a breath of fresh air, if we started to have managers that focused on value and end user experience and so on, which I think we're starting to get. I'm cautiously optimistic there. So my question for you is, if we're really going to make this turn, efficiency turn that you're describing, what health tech, product or service has the most potential? We're on productivity today, so productivity, but to improve systemic productivity in the healthcare industry? <Laugh>? Yeah, I know I ask you always these easy questions, <laugh>.

Murchinson:

Okay. Alright.

Burda:

Just having a sip of my coffee and listen.

Murchinson:

I haven’t even made coffee, Dave. I mean, it's so dark out here. Okay. Well, first I guess I would say my mind goes straight to triage, honestly. And you can address triage in so many ways, but triage is your first point of determining what needs to happen to that person. So let's go back a couple weeks to where we talked about AI bot doctors. If you actually help someone understand their symptoms and what's happening to them more before they see a human, that's a form of triage. It's extraordinarily powerful and inexpensive. And then once you actually have a person present and understand what they need initially, triages everything. And there are systems out there today that do an amazing job of just the human triage. Forget the AI bot doc stuff. Like just looking at,

you know, should you go to virtual, should you instead go to, you know, some sort of inventory outpatient, et cetera, should you get a lab first? Like, there's so many ways to think about creating capacity through triage. So I could ring that bell all day long. I do think that, you know, health systems are talking a lot about throughput, and throughput means so much to me. I mean, there's just so many different ways to think about this, Dave. I think because of where I lean today in terms of companies we see coming through, and where innovation's happening and where things are being adopted, it's much more on the administrative side today than clinical. I think there's probably a world of clinical technologies that we could be talking about, but just simple things that address both our labor shortages on the nonclinical side and just waste that we've been paying for for years. There's a whole bunch of those solutions that probably don't deal with throughput at all, but are really important, like autonomous coding and the like. So for the agentic solutions that are, you know, developing and we're seeing more and more of in the market, they're creating capacity among those individuals that can take on more patient care because they're not sitting on the phone with the health plan trying to get something improved. They're not sitting on the phone with the lab trying to figure out what the lab test is. There's a lot of that administrative time that's spent today by people who could be addressing patient care. And if we could just pull that kind of work off of them with agentic and automation technologies, they could see so many more patients and do so much more. And that to me is like the heart of throughput. So I know it's all sort of boring, Dave, but I look at all those things and say we could just redesign it with automation in mind and use the people much better.

Johnson:

Yeah. Productivity is the new sexy, you know, I gotta say.

Burda:

For sure. <Laugh>. Yeah. We used to say in the newsroom, don't be the person stopping another person from doing their job, right?

Murchinson:

Yeah.

Burda:

<Laugh>. So that was our, our philosophy. Thanks, Julie. Now I think this would make a great movie. You know, if somehow everyone got healthy overnight and no one needed healthcare, the economy would collapse and there would be total chaos. <Laugh>, it's, it's the exact opposite that is true of a zombie apocalypse movie, right? So feel free to steal that idea. Now let's talk about other big healthcare news that happened this week, Julie, what else happened that we should know about?

Murchinson:

Well, this happened last Friday, but our friend in digital health, Chris Klump, was promoted, I'm sure you saw that <laugh>. Now RFKs right hand overseeing all HHS operations, including his former role. So he is got a lot of influence.

Burda:

Yeah. These people wear a lot of hats in this administration, so you know, but that's a good choice.

Murchinson:

And well deserved, yeah,

Burda:

Yeah. Dave, what's your big healthcare news of the week?

Johnson:

Well, I love that one because we're gonna see what happens when competence meets crazy <laugh>, right?

Murchinson:

That's right. Exactly right.

Johnson:

And as long as we're on crazy, I mean, last week's decision of the FDA to not review Moderna's mRNA vaccine was one of the dumbest things I'd seen in a long time. And the FDA came to its census this week and reverse that. They are, now, going to review that. So that was good news. But the thing that caught my eye was the heartthrob from Dawson's Creek, James Van Der Beek unfortunately died at age 48 of, of cancer. I mention that; it's always sad, but I mentioned it because his family or friends of his family had to do a GoFundMe website to cover medical expenses and I guess living expenses. It's been hugely successful. They've raised 2.7 million with over 50,000 donations. So it pays to be a celebrity, but what does it say about our national safety net when someone of that prominence has to go beg for money, or his family has to go beg for money after after they die because of medical bills? We got a lot of work to do, people.

Burda:

Yeah, no, that's a real shame on the system. 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.