

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, March 26th. Two days from now on March 28th, there will be a nationwide No Kings protest against the current administration. You know what to do; I'm getting my sign ready, but are we ready for changing the way we pay doctors? We're gonna talk about physician market dynamics on today's show with Dave Johnson, founder and CEO of 4sight Health, and Julie Murchinson partner at Transformation Capital. Hi, Dave. Hi, Julie. How you two doing this morning? Dave?

David W. Johnson:

Well, it's opening day today at Wrigley Field and there's not gonna be any snow. It augers for a great season. <Laugh>

Burda:

Good luck to both teams. Thanks, Dave. Julie, how are you? Well,

Julie Murchinson:

Well, that's funny. I landed, landed in Boston Monday evening to snow, which was not what I really wanted. So- <laugh> ... When is it gonna end?

Burda:

Soon, I hope. Okay. Before we talk about physician market dynamics based on two new reports, let's talk about your plans for March 28th. Dave, are we gonna see you out on a street corner on Saturday?

Johnson:

4sight Health Roundup Podcast

3/26/26

Physician Compensation, Competition and Substitution

Well, we'll be there in spirit, but since it's relatively soon since Terry had her transplant, we can't go anywhere near that many people, so we'll be, we'll be cheering on from the sidelines, I guess.

Burda:

Yeah, live to fight another day, right? Yeah. Thanks, Dave. Julie, how about you? Will you be, , out in person or there in spirit?

Murchinson:

Well, I'll also be there in spirit because I'll be in Spain with a bunch of people who I don't want to reveal that I'm American, maybe. <Laugh> So, you know, but I'll be rooting for us. <Laugh> They'll probably be protesting, right?

Burda:

I mean, they hate him too. Oh, you never know. You never know.

Johnson:

I bet there's a No Kings protest in Spain.

Murchinson:

I bet there is too,

Burda:

Honestly. Yeah. It's global. It's global. Well, I'll be out in person. The only question is how clever and or offensive I want my sign to be. We'll see what I can get away with at home. <Laugh>

Johnson:

Yeah exactly. <Laugh>

Burda:

See if somebody hides the markers from me. <Laugh> We're also seeing how the market for physicians is changing based on two new reports. The first is a 14-page report on physician compensation models from the American Medical Association. The second is a 35-page report on physician competition from the National Bureau of Economic Research. I read them both so you don't have to. Here are the big takeaways from each report. According to the AMA report, which is based on a survey of 3,500 physicians, in 2024, compared with 2014, 39.2% of doctors were compensated based on only one of the following: salary, productivity, practice financial performance, or bonuses. That's down from 49%. 60.8% of doctors were paid based on two or more of those methods: salary, productivity, practice financial performance, and bonuses. That's up from 51%. 70.5% of physicians received a salary that's up from 61.2%, and 55% of physicians were paid based on productivity. That's up from 53.5%. Meanwhile, the NBER working paper by researchers from the University of Chicago and Cornell University said, "Organized medicine artificially limits the number of doctors and competition among doctors by limiting medical school seats and residency slots. But competition from nurse practitioners, physician assistants, and other mid-level practitioners threaten that market control because educational programs for those other types of clinicians are cranking them out. And the industry's ability to substitute other clinicians for doctors explains why the dire predictions of a physician shortage, quote, have not become apparent, close quote." And it doesn't sound like that's happening anytime soon. Dave, when you add up the takeaways from these two reports, what do you come up with? Are we paying doctors the right way to get the outcomes that, , we want?

Johnson:

Are we paying doctors the right way to get the outcomes we want? Is that really your question? 'Cause, You know, the answer is- I know the answer. I know the answer. Is, is a big fat no. Let's look at these two

reports. They each have an element of truth in them, although anything coming from the AMA has a huge grain of salt, to <laugh>, you know, take with it. But what struck me about that report in particular is how many physicians have to operate under multiple payment models. And if that's the case it's really hard to sort of switch back and forth and change away your practice to optimize performance under whatever payment model the patient happens to be covered by. And so you get conflicting incentives, disconnected from outcomes and so on. So I think just that disparity of payment models translates into lack of clarity on how to practice and certainly, complete disconnection from how to practice in ways that drive the best outcomes at the lowest cost with the best customer experience. The NBER report from the University of Chicago, you gotta love the economists, right? That's the study you should take home and put under your pillow and, you know, worship it on a daily basis. I just love their conclusion that there really hasn't been a shortage of physicians despite everyone, including the AMA, by the way, predicting the sky is gonna fall, and that's because much of what physicians do can be done by other types of professionals. And so the distribution of the work related to training and availability is happening in the marketplace writ large, and that's counteracting the retirement of physicians and so on. So when you read the NBER report, you find findings that are clear, accurate, and point the way to constructive policy solutions, right? Increase <laugh>, increase the ability of healthcare professionals to work at the top of their license, publish prices, create competition, and probably the loudest one is, you know, stop the medical protectionism that's baked into so much of the regulatory structure, particularly at the state levels, that prevents many, many, many logical things from happening that would both improve outcomes and lower costs. And, obviously in the process of doing that, increase access. And so I think bAbe Sutton at CMMI must have been reading the NBER report because many of these new payment models are really trying to align the incentives with the desired outcomes in ways we

haven't really seen before. So congratulations to Abe. Let's do it. Come on, people.

Burda:

Yeah, yeah. Well, the AMA really digs in its heel with that scope of practice stuff, doesn't it?

Johnson:

It sure does.

Burda:

Thanks, Dave. Julie, any questions for Dave?

Murchinson:

Yeah, Dave. I mean, how long have we been talking about this kind of topic and where are we? <Laugh> Okay, Dave, if you were a governor who wanted to improve access and lower costs, how would you attack the medical protectionism that limits practitioner supply and artificially increases compensation?

Johnson:

I just mentioned that so much of what clogs up the economics really occurs at the state level inside the medical associations where a lot of the barriers and the licensing actually prevent rather than promote better health access, health outcomes, lower costs, so on and so forth. So I, particularly on medical protectionism, I'd do more than this if I were governor, if I wanted to improve overall health. But on the protectionism part, day one in office, I would announce that I'm creating a blue ribbon committee that will look at all regulations inside the state with the goal of making my state the best place to practice healthcare in the country, easiest place to get licensed, easiest places to practice at the top of that license, greatest acceptance of new models, greatest flexibility, at least

with the payment levers I control to push incentives, push payment in such a way that it drives better health outcomes, higher prevention, health promotion, those kind of things, chronic disease management. And then the other thing I would do is I would start working, I'd get the best experts I could, and I would be working on the mother of all waivers. And I'd sit down with Chris Klomp and Abe Sutton and say, "I wanna be the beta site for how we should pay for healthcare in the country, and I wanna make my state the healthiest state in the country. Help me do that. What are the models we can use?" And I will take the hit. I will jawbone, I will go to every industry, and I will just push for whatever you all believe is the best way to drive better outcomes, lower costs, protect the taxpayer, all of those things. And the combination of those two really looking top to bottom at regulatory policy and taking on medical societies with logical reforms that actually promote the practicing of healthcare services at top of license that promote information sharing, that promote interdisciplinary care and interprofessional care, all of those things. And then, you know, when I'm ready to hit the home run, get the government at my back to make my state the one that really goes for it on payment reform and really get the incentives lined up to drive the outcomes we want. So the next time Dave asked me the question, "Are we paying physicians to get the outcomes we want?" <Laugh> I don't have to say it's not a big fan. No, it's a big fan, yes! Hallelujah.

Burda:

Thanks.

Murchinson:

Dave, for governor.

Burda:

<Laugh> Yeah. Oh, that's great. Thanks, Dave. Julie, your turn. What do you get when you add up these two new reports and where does technology and digital health fit into these economic equations?

Murchinson:

Well, from the back of the envelope, quick research I did on how these numbers have grown, like, NPs have grown a ton in the last decade, like over 125%, and I'm sure my numbers are off. And PAs, I mean, not as impressive growth, but, you know, pushing 50 to 70% growth over the last 10 years, like, a lot of mid-level happening here. So this is, like, a real thing. And first of all, <laugh> I'd like to think that, like, someone out there who's not the physician lobby is really just kind of going for it. So I try to think about where digital does fit in or really more so could fit in and maybe does so through some early stage companies today or through some functionality that's being added to, you know, existing or incumbent technology companies. But there's so much opportunity if you really think about digital health as the operating system for team-based care. Like, if you could actually think about how digital can standardize protocols, escalation, you know, make those mid-level, heavy models safe and efficient, thinking about better triage and decision support and even some of the supervision-related issues of team-based care, there's so much that can be done here with technology and, you know, I think you could start to apply some of the high growth models that use, you know, specialists kind of at the apex and mid-levels and, you know, the software that's kind of handling routine volume. Like you could pull that forward into a highly tech-oriented way and accomplish a lot to support where I think staffing's going. So I know I got excited about that. Like, I think in workforce planning today, I hear about this all the time, and it's not the sexiest area, but it's certainly talked about a lot. Like, a lot of the tools are really still so physician-centric. So if you really thought about expanding workforce planning tools with AI that's really thinking about how to ingest data and then allocate work and revenue and bonus pools across MDs, NPs, PAs,

based on their contribution and, you know, chronic care management and all the things that might go into a different way of paying, you can use technology to do a lot of things that we should be doing today. Humans aren't doing well. We could do a technology much better. So there's a lot of alignment opportunity. And I also think that ... I know we've talked about telehealth for so long, David's also kind of making me nauseous to keep thinking about it, but, telehealth and specialty care still, I think, has another day to go. Like, there's a 2.0 that's sort of here in some places coming in other specialties that I think could make a real difference in terms of how you start to think about, you know, the opportunity for specialists to deliver and get paid differently. So, I don't know. I think there's a lot that we could be doing to start to embrace how care delivery is shifting around these kinds of humans and what they're enabled to do. I don't like to use the top of the license phrase anymore, but I mean, we're getting there. And if we could just think about some of the digital rails that enable ACO and other kind of value-based models, like, we could be at a place soon if we really put our mind to it of how to embrace this and pay differently.

Burda:

What was that expression? You've got a face for radio? So I wonder if for a specialist, you need to have a face for telemedicine. <Laugh>

Murchinson:

Maybe. <Laugh>

Burda:

I don't know.

Murchinson:

Yeah, bedside manner. That's tougher.

Burda:

Yeah, it is tougher. Thanks, Julie. Dave, any questions for Julie?

Johnson:

Well, what's wrong with top of license? You know, it's a little bit like value. It's, it's getting kind of a bad name because everybody talks about it and nothing ever happens, but-

Murchinson:

Yeah.

Johnson:

... Why don't you like using top of licensing?

Murchinson:

'Cause It's just so overused. It's like the word innovation, transformation. Yeah. Like all of them. <Laugh> Yeah.

Burda:

Okay.

Johnson:

Okay.

Burda:

See, you need a vacation. That's what I say.

Murchinson:

We do. I do. Right? Can you tell? <Laugh>

Johnson:

Yeah. Well, as I said on one of these podcasts, my vote for the most overused word of 2026 is agentic. <affirmation> If I never hear that word again, I'll be happy. But anyway Julie, to the question, to the task at hand, to the job to be done. What happens when the irresistible force of the marketplace's quest for value as embodied in the NEBR report that Dave talked about. What happens when that quest confronts the immovable object that is medical protectionism, particularly for doctors, you know, that would be the AMA's perspective. And perhaps more importantly, are the cracks that are resulting from this epic confrontation big enough for new disruptive entrants to gain footholds and shift industry supply demand dynamics so that when we talk about top of license and value, we actually mean it.

Burda:

<Laugh> Easy one for you there, Julie.

Murchinson:

Yeah.

Johnson:

Total wheelhouse for Julie.

Murchinson:

Listen, I think that, I don't wanna speak ill of the potentially almost dead, but the AMA is ... Like we have a lot of associations that are asleep at the wheel and advocating for the wrong things. We talked about lobbying what, in the last couple weeks, and the funds going behind, you know, trying to maintain a status quo or something that's not as bad as what the future could be. And you know, we're seeing innovators every single day that are recognizing ... Okay, so many AI forward models that we've talked about over the last couple months, right? But we're seeing innovators every day that are actually really

leaning into the service model. We're seeing service models that are really leaning into their technically enabled access. And if doctors aren't careful, they're gonna have more of these mid-levels come up and be able to do more and more and more. And Venokosla's view of the world is going to come true, which is, you know, ... I don't wanna put words in his mouth because he says a lot of different things a lot of different ways, but, like, primary care will be able to do a lot of what specialists do, and specialists would do, like, a very little amount. Or some specialists would kind of do it all and be paid in a really different way. But at the end of the day, if an ODC is the fact that we don't even need physicians at all. I don't know if I agree with that, but we're so much closer to Venod's reality than I think we are to Marcus Welby. So, you know, the protectionists have another thing coming, and I don't know how long it's gonna take. I think there's a lot of barriers to AI really being able to have the impact that everyone's super excited about, but maybe that extends it a couple years. We're not talking about Neverland.

Burda:

Getting closer every day. That's great. Thanks, Julie. For me, you know, more market competition will cure a lot of ills in healthcare. And I think Dave, like we always say, you know, same with paying for the outcomes we want, right? Not for how many patients a doctor sees. And the sooner both of those happen, the better for healthcare consumers. So now, let's talk about other big healthcare news that happened this past week. Julie, what else happened that we should know about?

Murchinson:

Well, I'm sure you may have seen some of this recently, but inside the Beltway, they've been pretty active. CMS has, again, launched an Aspire Medicaid model in pediatrics, and the FDA has approved a higher dose Wegovy. Triple strength.

Burda:

Hmm.

Murchinson:

So lot of, lots happening inside the beltway.

Burda:

Wow. That'll be interesting to see the market impact of that. Dave, what's your big healthcare news, Louie?

Johnson:

Triple dose. It's gonna reverse aging too. <laugh> I bet Benjamin Button was the first patient.

Burda:

I'm waiting for the quadruple. <Laugh> That's, you know, not wasting my time with triple. Go ahead, Dave. I'm sorry.

Johnson:

Triple, yeah. <Laugh> No, no, that's fine. I can't wait for you to get it. I'm gonna stick inside HHS too... Julie mentioned a few weeks ago for her news of the week when Chris Klump became the chief of staff for RFK and that's starting to.... His fingers are now on the pulse of some very interesting personnel choices. So today, Bakalaria's appointment runs out as CDC director, so they gotta get a new one of those. And Prasad, who was overseeing biosimilars and vitals, he's out now. He was incredibly controversial. And Chris is overseeing the replacements. And I gotta say, every time I've heard Chris Klump speak, he starts off by praising the people inside of CMS and how much they've taught him, how great they are for the country and so on. There's no talk a deep state here at all. So what he said in an interview last week that he wants a CDC director, and by implication, a new head of vaccines and FDA with

4sight Health Roundup Podcast

3/26/26

Physician Compensation, Competition and Substitution

‘unassailably high moral integrity who is deeply experienced and is qualified to lead a staggeringly complicated and essential government agency’. Come on, Chris, more power to you.

Murchinson:

Go, Chris. Yeah. For sure.

Burda:

Yeah, good to have an adult in the room. That, that's, that's great for everyone. Thanks, Dave. And thank you, 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](http://4sighthealth.com). You also can subscribe to the Roundup on Spotify, Apple Podcast, YouTube, or wherever you listen to your favorite podcast. Don't miss another segment of the best 20 minutes in healthcare. Thanks for listening. I'm Dave Burda for 4sight Health.