4sight Health Roundup Podcast
Do We Really Need More Hospital Beds? 2/27/25
Podcast Transcript

David Burda:
Welcome to the 4sight Health Roundup podcast, 4sightHealth's podcast series for healthcare revolutionaries, outcomes matter, customers count and value rules. Hello again, everyone. This is Dave Burda, news editor at 4sightHealth. It is Thursday, February 27th. Never thought we'd side with Russia over Europe. That again, I never thought we'd elect a convict and felon as president. Want another surprise? We may need more hospital beds, at least according to a new study that we're gonna talk about on today's show with Dave Johnson, founder and CEO of 4sightHealth, and Julie Murchinson partner at Transformation Capital. Hi, Dave. Hi, Julie. How you two doing this morning, Dave?

David W. Johnson:
What a difference a week makes. Last week, we were in the deep freeze this week, spring has sprung, and I have a spring in my step. See what I did there? I just love the English language. <Laugh>.

Burda:
Yeah. I'll say shorts and t-shirt weather, right, Dave?

Johnson:
Exactly.

Burda:
Julie, how are you?

Julie Murchinson:
Well, I spent a couple days with my team in glorious San Francisco. It hit 68 degrees and Bluebird skies yesterday, so no complaints. But the highlight of my week was my Waymo ride. I love that thing. The autonomous car.

Burda:
What? <laugh>?

Murchinson:
Yeah. It's amazing.

Burda:
Really? Wow. Wow.

Murchinson:
Program my own music. It's Waymo Good. It's good. It's Waymo good.

Johnson:
Waymo good.

Murchinson:

I see what you did there, Dave. Yeah.

Burda:
Yeah. You do love the English language. That's great. <Laugh>. Oh, okay. Before we talk about the market for hospital beds, let's talk about other things you thought you'd never see in healthcare this year. There is certainly a lot to choose from. Dave, what happened during the first two months of 2025 in healthcare that you thought you'd never see, good or bad?

Johnson:
Well, a whole slew of things have happened, and what is unusual is I think the US healthcare system has entered into this unprecedented period of disequilibrium where small changes in events can have disproportionate impact. That's both bad and good news. There was another shooting this week at A-U-P-M-C hospital in York, Pennsylvania that killed two people and wounded five. Got very little notice. The Trump administration is running roughshod over Medicaid. Too many innocent Americans will get hurt but perhaps needed changes will also emerge. It just feels like a ticking time bomb out there, which I've never really felt before to the extent I feel right now.

Burda:
Yeah. It's like we've lived a lifetime and just two months already. Julie, what have you seen this year in healthcare that you thought you'd never see?

Murchinson:
I never thought I'd see a death from measles.

Johnson:
Ha!

Burda:
Yeah. Okay.

Johnson:
And it's not gonna be, it's not gonna be the only one, right? No.

Murchinson:
<Laugh>, it's, I mean, we're gonna see a lot of 'em down there.

Burda:
Yeah. That's the future. All right. I will add that in. That is, that is shocking that it's been 10 years. I read it was 2015, so 10 years, right?

Murchinson:
Yeah. It's not like it's that unusual, but it is like, what's going on down there? It's just the, the point of what we're gonna see.

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Johnson:
Measles was eradicated. I mean, no deaths, no measles in 2000, right?

Murchinson:
For years.

Johnson:
Yeah. So this is all comeback since then. Thank you. RFK Jr, right?

Murchinson:
Yes, that's right.

Burda:
Yeah. It's gonna be nasty. Thanks Julie. For me, it was my Medicare card. Not that I didn't think I'd lived this long, but it was a remarkably simple and painless experience. I applied for Medicare part A and part B, got my card. Then I applied for the Part D drug plan. Got my card all within 30 days, believe it or not,

Johnson:
But it's paper. It's a paper card. <Laugh>. Come on. Get into the 21st century. Geez.

Burda:
Yeah. Yeah. They make great perforations. Right? You know, <laugh>, it came outta that bigger sheet of paper pretty easily. So thanks to all the federal healthcare workers toiling behind the scenes for years who made this an easy and seamless process. Now, I hope you all find new jobs soon. Okay. Let's talk about the hospital bed market. We talk all the time on this show about how we need more health and less healthcare. That translates into fewer hospitals, fewer hospital beds, and less inpatient capacity. Now, a new study that's gotten a lot of attention says, we're all wet. Let me tell you about it and get your reaction. The study appeared in GM and Network Open on February 19th. It was done by health services researchers at the UCLA medical school and the greater Los Angeles VA. They said the average US hospital occupancy rate was 63.9% during the 10 year period before the pandemic. After the pandemic. When the public health emergency ended in 2023, the occupancy rate rose to 75.3%. That increase was due primarily to a nearly 16% decline in the number of hospital beds between those two periods, from 802,000 down to 674,000 with a projected increase in hospitalizations because of the aging population. Without adding any new hospital beds, the occupancy rate will shoot up to 85% by 2032, or in just seven years. They call that occupancy rate dangerous. We would need a 10% increase in hospital beds, along with a 10% decline in projected hospitalizations to avoid a crisis. And just when I got my Medicare card. Dave, what do you think of all this? Are we headed for a hospital bed crisis, and what can we do from a policy perspective to avoid it?

Johnson:
Yeah. The future is already here. It's just unevenly distributed, right? This particular analysis uses straight line projections to reach its conclusions. That means it misses the very uneven distribution of hospital beds throughout the country. There's no shortage of hospital beds. In my

neighborhood of Lakeview in Chicago. Advocate is spending a billion dollars on a new patient tower. The, just a couple of blocks from here capacity correlates with levels of commercial insurance coverage. Everybody knows that we don't do much about it, but everybody knows that. And that's why low income, rural and urban communities disproportionately experience the negative impacts and increased mortality associated with inadequate access. And it's only going to get worse with all the proposals in the new Trump administration's budgets that will slash Medicaid spending across the country. Secondly, the problem is real. We've started watching the new HBO series, The Pit that chronicles hour by hour activity in an overwhelmed Pittsburgh Emergency Department. Noah Wiley plays the lead physician. And he is incredible in the role. Most remember him as the wet behind the ears doctor in er a million years ago. But he's really mastered that, that role of managing in a chaotic environment. The stresses on caregivers are just enormous. It actually makes me angry watching this, Dave, because I think of all the great dedicated, talented people working away under these miserable conditions and just can't stand the fact that we can't organize our resources in such a way as to get them better conditions in which to work. The boarding issue is tangible in this show. As, as patients get stashed in the ED until beds become available in the main hospital. You know, in one scene, an administrator comes down to the ED and Chastises the Noah Wiley character for its Low Press Ganey Scores.

Burda:
<Laugh>

Murchinson:
Did they say Press Ganey?

Johnson:
Yeah. Oh, yeah. And they, they threaten his job and he, he responds. He goes, what do you expect when we've got people stashed for hours and days in the ED waiting for a room upstairs? She, she could care less. The administrator could care less. She just says, you know, get your scores up. So third thing… Meatloaf sang two out of three ain't bad. Remember that song <laugh>?

Burda:
Right?

Johnson:
And the Iron Triangle for hospitals is simultaneously trying to achieve high quality, lower costs, and increased access. There was a 1994 book by William Kissick titled, medicines Dilemma, infinite Needs and Finite Resources. And Kissick states the dilemma quite nicely. The US system can get two of three of these goals. You know higher quality, lower costs, and increase access. But not all three. There just isn't enough money to make that happen. But I find this type of linear thinking, extremely dangerous. The first thing you need to do when you're in a ditch is to stop digging massive new investment in hospitals, as this analysis suggests we need, and many support is not the answer. More of the same approach to providing healthcare in this country will provide more of the same dismal outcomes as Steve Jobs might say. It's time to think different. You know, let's figure out how to keep people healthier. How to eliminate waste decreased

demand for hospitals because we got healthier populations. You know, remember Einstein's definition of insanity doing the same thing over and over again and expecting different outcomes. It's just not gonna happen.

Burda:
I don't know whether I should watch that show, the Pit, Dave, or just avoid it like the plague, 'cause…

Johnson:
We can only watch one episode at a time. It's that intense. but I'd recommend it. I mean, it's…

Burda:
Oh, yeah,

Johnson:
…doing what we do it…

Burda:
Yeah,

Johnson:
…It's nice grounding.

Burda:
Got it. Thank you. Julie, any questions for Dave?

Murchinson:
Wow. Gosh, another show. <Laugh>. you know, Dave researchers in this study really looked at hospital bankruptcies and private equity's role and, and really pointed the finger there. Can you see a world where public-private partnerships are more robust or private equity could actually help this kind of doomsday scenario?

Johnson:
Yeah. The, the researchers are missing the forest for the trees of, of course, I can imagine a world where private equity and public-private partnerships contribute to the solution. But that's means that we get the payment incentives, right? And, you know, we've been trying to do that forever and just haven't been able to achieve it. But if we can, and again, that's a big, if PE and other public-private ways of doing things can deliver low cost, high quality hospital operations, there's no reason they can't. In the meantime though, absent that type of radical payment reform, PE owned facilities will exploit opportunities to find excess profits. Remember, they're heat seeking missiles for profits. That's what they do. And there's an amoral quality to the space. So things like out of network billing, service line decisions, only doing things that generate a profit and excessive cost cutting will be the norm. And that's what we see all over the place. You know, and by the way, lots of nonprofits are doing exactly the same thing. So it's not like we should be just picking on just private equity owned hospitals. But if we can't get the payment models right the

country will need to move to a utility model with all of the issues that, that portends. Hello, Europe.

Burda:
I'm getting worked up and it's not even nine o'clock central. All right,

Johnson:
<Laugh>. I've done my job.

Burda:
Yep. You've flipped the switch. Dave All right. Julie you're younger than Dave and me much younger. Do you think there'll be a hospital bed if and when you ever need one? And what can the market do to make sure you have one? If you do?

Murchinson:
I just wanna underscore much younger.

Burda:
Yeah. <laugh>, I won't cut that out.

Johnson:
How old are you when you don't know how old you are?

Murchinson:
<Laugh>, You know, this is a tough one. I mean, we've, like Dave, we've talked about it for years, but we are at the stage where we're gonna have more people over 65 and under 18. So I don't know. I believe we are likely under bed in certain regions, and, but the devil's in the details for sure, and I was kind of intrigued by the, some of the drivers that they pointed out, like it's, you know, they said it's not really being driven by increase in hospitalizations, but by decrease in staffed hospital beds, right? So this is really comes back to workforce, nursing workforce, physician workforce. And while we've been talking about shortages in these areas for a long time, we all know that this has been kind of a more recent acute issue. And it doesn't help, of course, that I think our state department has a freeze on international nurses still, maybe. So, you know, when I talk to people in the market about things like this, I learn interesting tidbits. And one interesting factor that I learned this week from a health system leader who used to be in Louisiana and is now in California, that there's a stat that's, don't quote me exactly, but goes something like this, Louisiana, you know, they saw this physician shortage coming and they partnered with a number of medical schools in the state to really ramp up programs. And they are graduating as many doctors or perhaps maybe as many residencies in California this year as they are in Louisiana. So just think about that for a second. Think about how much larger California is than Louisiana and Louisiana planned because their back was up against the wall. And states like California maybe have not felt that back up against the wall yet. So I think we are getting to one of those moments when healthcare does react with their backup against the wall. And I was stunned to read in this study that the author said, we need more innovative care delivery models

that can reduce hospitalizations by diverting would be admissions to specially designed acute care clinics. That's a quote.

Johnson:
Hello? <laugh>

Murchinson:
<laugh>. I mean, where have you been? Yeah, so like, there's something going on here. And if we can use moments like this to not use this study to build more beds, but to actually really work on triage systems and, you know, alternative sites of care, like what a win that would be. So, UCLA is taking the opportunity to market their next day clinic solution, which is trying to divert patients to different levels of acuity care. And you know, I've seen plenty of examples where this is working around the country. Highmark actually, unlike many systems that have not had success with these micro hospitals, Highmark is having success with micro hospitals. We're seeing it in home-based models. We've gone through kind of a hospital at home V1, and I think we will see kind of a hospital care at home model that perhaps looks very different in V2. But my questions for the study are like, okay, does the data look at data by region and diagnosis, are they looking at admissions that could have been avoided in some of these ways? There's so much in here that could be done. And it's just frustrating to think that this study could be used in ways that, that it shouldn't be in areas that actually are not under bedded.

Burda:
Right? Yeah. The answers are out there, and let's hope this doesn't paint over them. Thanks, Julie. Dave, any questions for Julie?

Johnson:
Well, Julie <laugh>, I loved your answer. And by the way, the answer to all your questions is3 no, it was just straight line analysis. But I really liked what you were doing around the margins there. It reminded me of that Buffalo Springfield song from the seventies. There's something happening here. What it is ain't exactly clear. And I think this study is just a classic example of the dangers of linear thinking. So here's my question for you. Pretty simply, what, what's your favorite non-linear solution to this presumed hospital bed crisis?

Murchinson:
Oh my God, I don't just have one favorite. Like, imagine if we could do just simple things like pre and post-surgical care better. UPMC is doing this for their rural population. It's reducing, like this day it's creating more convenience for patients. Like, there's a just simple, simple solution. Of course, my favorite day if you know, is preventative care and early intervention, but I've, you know, long kind of hung that up. I mean, let's talk about crazy ideas. Like imagine if hospitals in you know, certain regions collaborated and could dynamically allocate bed capacity across the region. Never gonna happen. But, you know, there are some, there's some wishes on the list there. I think what's really happening out there, like real, this is real example, one of the largest health systems in the country is absolutely feeling the impact of GLP ones on bariatric surgeries. I think I've talked about this here before mm-hmm <affirmative>. But, you know, when I sit with a system that tells me that and is trying to figure out how to get ahead of that and how to get a

cut of that, I mean, that's back up against the wall. Another kind of real set of examples, I'm watching some of the largest systems in the country actually adopt smart front door strategies that are helping patients triage to the right level of care across their now new kind of service line, developed sites of care. They're, you know, the largest systems in the country see that they need to compete in their local markets. And they're starting to not necessarily do this out of capacity problem issues, but out of business model drivers. Right. So, you know, is that non-linear? I dunno,

Johnson:
Yes. <Laugh>

Murchinson:
Yes. But there they're examples are real and we need to see more of them.

Burda:
Thanks, Julie. Well, my prediction is the what we all fear based on this conversation is that the numbers in this study are gonna appear in a lot of PowerPoint presentations to justify building more hospitals and adding more hospital beds. So you guys go to more presentations than I do. So let me know when you see it and we'll talk about it. Let's talk about other big healthcare news this week. I know you know it when you see it. Julie, what else happened that we should know about?

Murchinson:
Well, Dave mentioned this at the top of the show, but this shooting at UPMC, I mean, what is happening in the world? And I talked to a couple folks from UPMC earlier this week, and they're rocked. So I think healthcare isn't ready for the onslaught of crazy that's coming its way, it's sad.

Burda:
Dave, what other news is worth mentioning?

Johnson:
Well, I got a couple of things. One, Dave, your comment about the PowerPoint presentations, I'm giving a speech to a Michigan Architects Association in a couple of weeks.

Burda:
<Laugh>

Johnson:
400 people attending. That's just Michigan <laugh>. Yeah. and well anyway, it's gonna continue until it doesn't. This week renowned healthcare futurist Ian Morrison died at the age of 72, which actually seems young to me now. He was an astute, funny guy. He liked to say he'd gone from Scotland where death was imminent to Canada, where death was inevitable to California, where death is optional; we'll miss Ian. Goldman Sachs was out this week with a study that said they expect 60 million people to be on the GLP one medications by 2028. And that will boost

productivity in the United States by 1%, several trillion dollars because people will be healthier and more productive.

Murchinson:
Wow. That's big.

Burda:
That's great. Okay. Yeah, alright. Some good news to end the show. Very, very good. Thanks Dave. 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@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.