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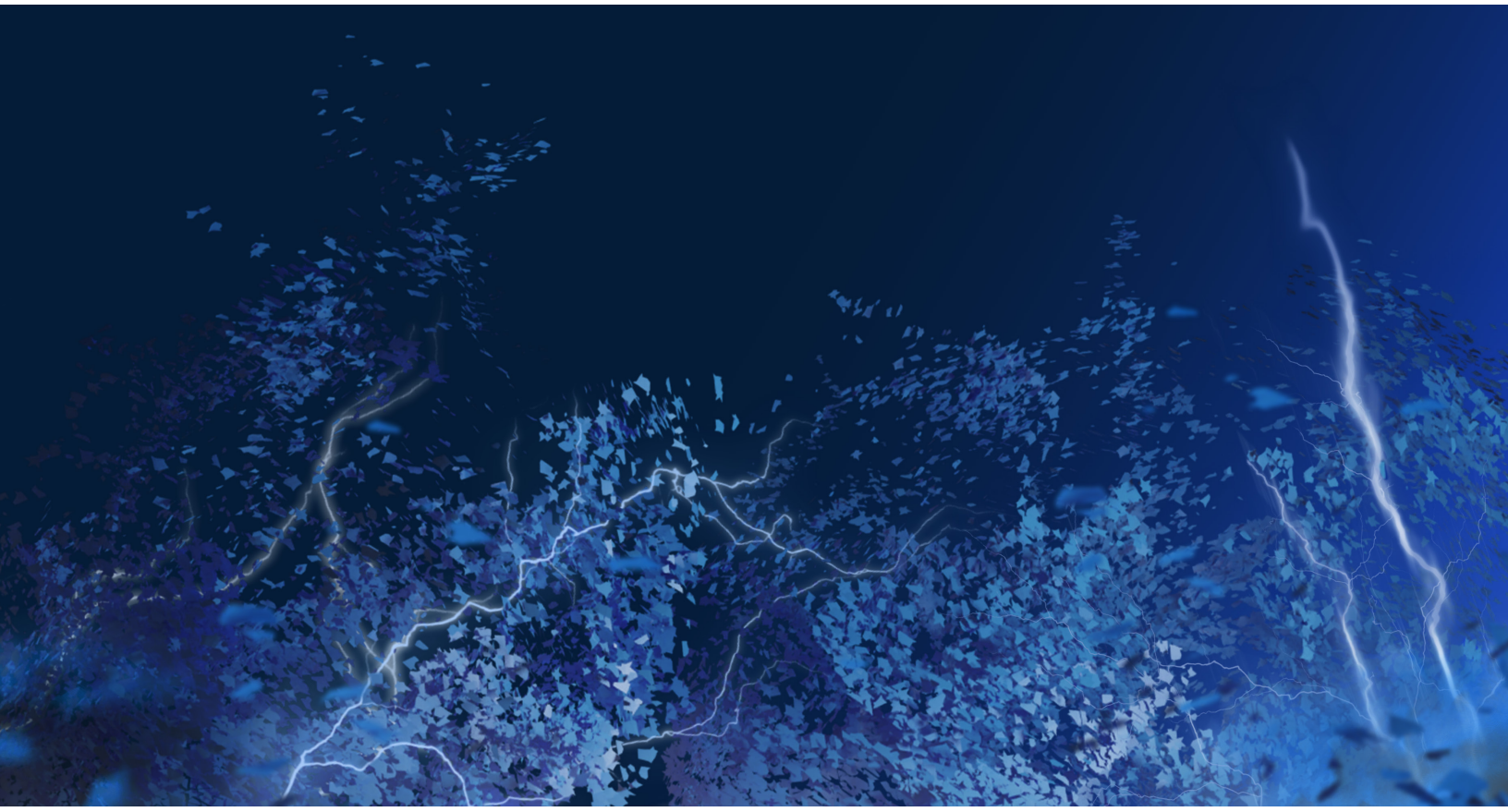
The gathering storm: The uncertain future of US healthcare

Forces are acting to challenge affordability and access in healthcare and threatening the industry's economic outlook. At-scale innovation is key to filling the gaps.

by Shubham Singhal and Addie Fleron



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The once-in-a-century pandemic thrust the healthcare industry into the teeth of the storm. The combination of accelerating affordability challenges, access issues exacerbated by clinical staff shortages and COVID-19, and limited population-wide progress on outcomes is ominous. This gathering storm has the potential to reorder the healthcare industry and put nearly half of the profit pools at risk.

Those who thrive will tap into the $1 trillion of improvement available by redesigning their organizations for speed to accelerate productivity improvements, reshaping their portfolio, innovating new business models to refashion care, and reallocating constrained resources. The healthcare industry has lagged behind other industries in applying these practices; players that are able to do so in this crisis could set themselves up for success in the coming years.

This is the first in a four-article series, where we address the following questions: what are the major storm clouds on the horizon, and how does the potential impact compare with past periods of upheaval; how does rising inflation—both broadly, and specifically, as the industry confronts a clinical staff shortage—affect access, costs, and growth; what impact might an endemic COVID-19 have on the expected trajectory of healthcare costs; and what should stakeholders do about it?

The turbulence that lies ahead

The arrival of the COVID-19 pandemic marked the end of a decade of relative calm in US healthcare. From 2010 to 2019, real spending on healthcare rose only 0.3 percentage points above growth in real GDP. This compares with a 3.0 percentage-point differential in the decade before the enactment of the Affordable Care Act. Historically, periods of acceleration in healthcare costs well above the growth of the economy have resulted in fiscal interventions by the government (Exhibit 1). Moreover, economic

Exhibit 1

Periods of elevated national health expenditure have been associated with fiscal constraints.

Growth in national health expenditure (NHE) above GDP, % (not exhaustive)

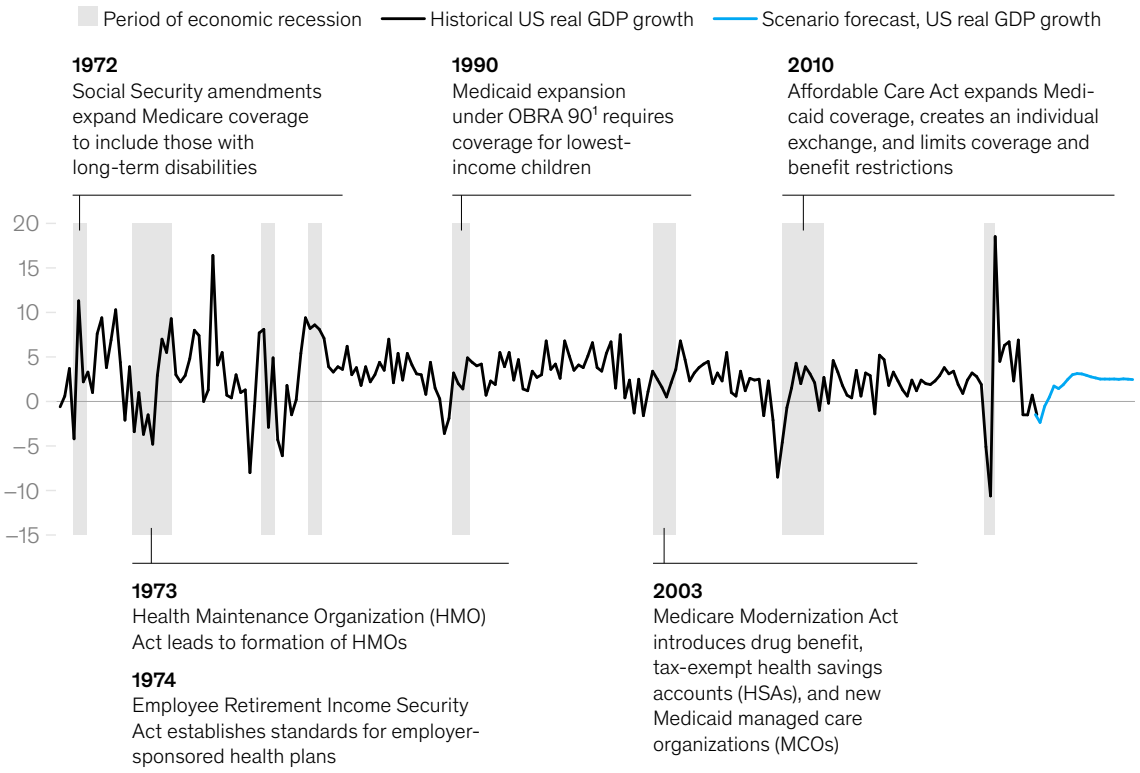
	1970	1982	1990	2002	2009
Fiscal intervention	1971 President Nixon's executive order forced freeze of healthcare prices and wages	1983 Introduction of Medicare diagnosis-related group payment system	1997 Balanced Budget Act enacted, introducing sustainable growth rate	2005 Medicaid modifications included in Deficit Reduction Act	2010 Medicare productivity cuts in Affordable Care Act 2011 Medicare sequestration included in Budget Control Act
NHE growth in following years	Growth in NHE fell below GDP growth by 1973; returned to elevated levels in 1974–77	Growth in NHE fell below GDP growth by 1984; began to rise again in 1985	Growth in NHE fell below GDP growth by 1994 during the 1990s managed-care era, and the second-longest period of low growth from 1994–2000 was sustained by Balanced Budget Act	Growth in NHE returned to near level of GDP growth by 2004 and stayed low through 2006	Growth in NHE fell below GDP growth by 2011, the longest period of sustained low growth from 2011–19

Source: National Health Expenditure Data, US Centers for Medicare & Medicaid Services; World Bank Group

Exhibit 2

Regulatory changes have frequently followed economic recessions.

US GDP growth (real) from previous quarter, annualized % change (not exhaustive)



[1]Omnibus Budget Reconciliation Act of 1990.
Source: National Bureau of Economic Research; US Bureau of Economic Analysis; US Bureau of Labor Statistics; McKinsey Global Institute

recessions in these periods have led to broader healthcare reforms (Exhibit 2). As inflation persists at the highest levels since the 1970s, the economy has experienced two successive quarters of negative GDP growth and heightened risk of a recession. As a result, the potential for discontinuous change in healthcare has increased.

Our analysis finds that national health expenditure could grow at a rate of 7.1 percent over the next five years from 2022 to 2027, compared with an expected economic growth rate of 4.7 percent. In aggregate, this would equate to healthcare expenditure growth in excess of economic growth of 2.4 percentage points. Health expenditure growth could exceed economic growth by up to 5.9 percentage points in 2023, creating enormous affordability pressure. The potential for healthcare expenditure growth to exceed economic growth so significantly in the shorter term is driven by a combination of current high inflation, a persistent clinical staff shortage, and lower economic growth in 2023 (Exhibit 3).

The potential for discontinuous change in healthcare has increased.

Forces fueling the storm

The combination of significantly higher healthcare costs than expected and the challenges facing end payers—employers, consumers, and government—will face in paying for this increase will force a reckoning in the industry.

Annual incremental healthcare costs of $590 billion

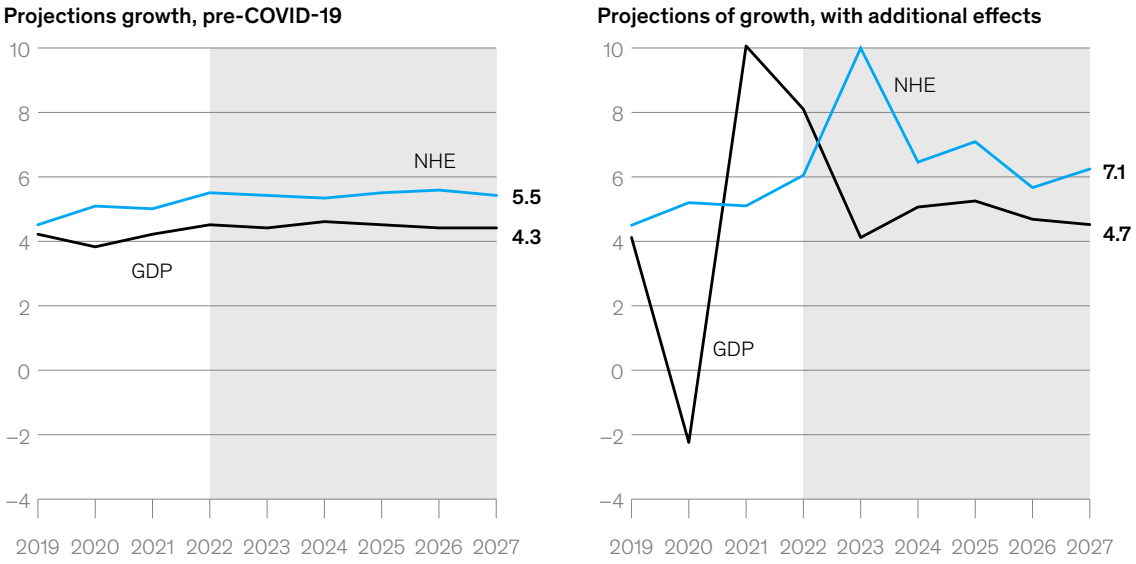
By 2027, US healthcare costs could be $590 billion higher than the projected $5.8 trillion expected in the estimates made pre-COVID-19 (in 2019). Heightened inflation accounts for $370 billion of this difference,[1] of which 40 percent is driven by elevated clinical labor inflation rates linked to a shortage of clinical staff.

The United States is projected to face a shortage of more than 200,000 registered nurses and more than 50,000 physicians in the next three years.[2] In addition to fueling persistent inflation, this clinical staff shortage is likely to create challenges in healthcare access and potentially exacerbate health inequities. Growth and margins for providers are already

Exhibit 3

National health expenditure growth with incremental effects could significantly outpace GDP growth over the next two to three years.

Projected national health expenditure (NHE) growth compared with GDP, 2019–27, % CAGR (nominal)



NHE growth in excess of GDP growth, percentage points

2022	2023	2024	2025	2026	2027
1.2	1.2	0.9	1.2	1.4	1.2

2022	2023	2024	2025	2026	2027
–2.1	5.9	1.4	1.8	1.0	1.7

Note: For pre-COVID-19 projection, nominal NHE growth and nominal GDP growth based on March 2020 NHE release; nominal NHE growth, with additional impacts, is based on March 2020 NHE release for 2019–21 and March 2020 NHE release, plus additional modeled impacts for 2022–27; nominal GDP growth is actuals through 2021 and projections from 2022–27 based on McKinsey analysis in partnership with Oxford Economics, scenario 3B.
Source: *National health expenditure projections 2019–28*, US Centers for Medicare & Medicaid Services, Mar 24, 2020; McKinsey analysis

[1] Estimate is based on potential increases in spend associated with excess inflation above historical trend. Nonlabor inflation rate based on forecasted changes in private services consumption deflator; nonclinical labor inflation rate is based on wage index forecasts that model the historical relationship between wage growth and CPI growth; clinical labor inflation rate is based on expert experience. Modeled economic indicators based on McKinsey analysis in partnership with Oxford Economics.

[2] Gretchen Berlin, Meredith Lapointe, Mhoire Murphy, and Joanna Wexler, "Assessing the lingering impact of COVID-19 on the nursing workforce," McKinsey, May 11, 2002; *The complexities of physical supply and demand: Projections from 2019 to 2034*, Association of American Medical Colleges, prepared by IHS Markit Ltd., June 2021.

End payers, already struggling to afford healthcare, have limited ability to absorb this potential acceleration in costs.

strained due to this dynamic, and the impact is likely to worsen. Testing, vaccination, and treatment of endemic COVID-19 and the associated increased burden of behavioral-health and other chronic conditions could add another $220 billion in annual costs over the next five years.[3]

Affordability challenges faced by end payers

End payers, already struggling to afford healthcare, have limited ability to absorb this potential acceleration in costs.

Employers have continued to shift the cost of healthcare to employees. For example, 18 percent of employees were enrolled in high-deductible health plans in 2013.[4] In 2021, 40 percent of employees were enrolled in these health plans.[5] In addition, in 2019, the average family contribution to coverage was 32 percent for employees at companies with more than 500 workers and 53 percent at those with less than 499 workers.[6] In our recent survey, 95 percent of employers stated that they would adjust benefits if cost increases were 4 percent or higher, with the most common changes being increasing employee cost sharing, shifting to high-deductible health plans, and optimizing the provider network.[7]

Consumers already face significant exposure to healthcare costs, as noted above, with the rising level of cost sharing in employer-sponsored insurance. In 2021, the average family faced an estimated annual exposure before coverage of $8,000 to $12,000.[8] With $20,000 in average household savings in 2021, consumers' ability to absorb this exposure is limited.[9] Furthermore, 22 percent of consumers report having more than $1,000 of medical debt, 34 percent of those who chose to defer care stated it was due to lack of affordability, and 45 percent of consumers state that a $10 increase in the cost of a physician visit would lead them to avoid it.[10] Moreover, while US workers are seeing nominal wage increases, inflation has eroded the gains, resulting in negative real earnings growth.[11] Consumers' satisfaction with employer-sponsored health-

[3] Range is $137 billion to $379 billion, based on scenario analysis from McKinsey's COVID-19 Epidemiological Scenario Planning Tool (v13.3). The analysis includes a range of 110 million to 220 million annual cases, of which 10 to 15 percent require outpatient treatment; 4,100 to 6,100 per day require a non-intensive care unit (ICU) hospital admission; and 400 to 900 per day require an ICU admission. Cost of treatment from Blue Cross Blue Shield and Fair Health; all figures scaled to nominal 2027 estimates. Long COVID-19 treatment costs are based on an estimate that at least 3 percent of cases result in long COVID (UK Office for National Statistics) for three to 12 months; published estimates of long COVID-19 symptoms (UpToDate); and standard treatment costs for those symptoms (Medical Expenditure Panel Survey). The upper-bound estimates of long COVID incidence assume about 20 million US long COVID cases per year, based on data on current rates of long COVID from the US Census Bureau's July–August 2022 Household Pulse Survey. There is significant uncertainty in ascertaining prevalence and resulting cost impact of long COVID, and data continue to become available on a frequent basis as more research is conducted. Our aggregate analysis, using these enumerated data sources, employs a point estimate of $19 billion as a conservative estimate. For both ongoing COVID-19 treatment and long COVID, higher incidence rates would result in an estimate at the higher end of the range. Testing and vaccine estimates are based on 2021 costs per test and per vaccine and data from US Department of Health and Human Services and the US Centers for Disease Control and Prevention as to annual demand for testing and boosters. For this factor, higher utilization of testing (times per person per year) would result in an estimate at the higher end of the range. All figures are scaled to nominal 2027 estimates.

[4] Mercer 2021 Survey of Employer-Sponsored Health Plans. Value reflects enrollment in consumer-driven health plans, which primarily consist of health savings account–eligible high-deductible health plans.

[5] Ibid.

[6] US Census Bureau, American Community Survey Data, 2019; Board of Governors of the Federal Reserve System, Survey of Consumer Finances, 2019.

[7] 2022 McKinsey Healthcare Stakeholder survey, July 1, 2022.

[8] Mercer 2021 Survey of Employer-Sponsored Health Plans.

[9] Estimate based on US Census Bureau household data and Brookings Institution household finance data; this estimate is subject to fluctuation, including during depressed spending periods due to the COVID-19 pandemic.

[10] McKinsey Consumer Health Insights Survey, February 2022.

[11] Wage and inflation indicators from Federal Reserve Bank of St. Louis.

care coverage is lower than their satisfaction with Medicare, Medicaid, or individual health insurance exchanges coverage.[12]

The government may also not be prepared to fund the increase in healthcare costs. The 2022 Medicare Trustees report projects that the hospital insurance trust fund balance will turn negative in 2028, limiting the federal government's room to maneuver as it relates to costs.[13] Recent implementation of 2 percent Medicare sequestration cuts illustrate this issue. If the Medicare trust fund needs to pay for additional healthcare spending, this timeline for trust fund insolvency could accelerate. In addition, federal debt stands at 123 percent of GDP.[14] As the Federal Reserve raises interest rates and shrinks its balance sheet, interest payments on federal debt are expected to double as a proportion of the US budget between 2022 to 2027.[15]

Implications of the storm on the healthcare industry

It is not clear that end payers—employers, consumers, and government funders—will be able to bear this increase, leaving industry players to address the additional spending or face significant EBITDA risk. The forces noted above could put $450 billion of EBITDA[16]—more than half of the total projected 2027 profit pool—at risk. However, there is a $1 trillion improvement opportunity available in healthcare. It provides the best avenue to improve healthcare for all stakeholders and alleviate the potential margin pressure on the industry. Four areas make up this opportunity:

— *Care delivery transformation.* The future of care delivery in the United States is evolving. It is becoming patient-centric, virtual, ambulatory, and available at home. It is also becoming value-based and risk bearing; driven by data and analytics; more transparent and interoperable; enabled by new medical technologies; funded by private investors; and integrated yet fragmented. This radical transformation of the industry introduces potential savings of $420 billion to $550 billion. To capture this value, the transformation must happen much more quickly than the current course and trajectory suggests. For example, achieving these savings would require, among other efforts, shifting 20 to 25 percent of hospital-based volume to alternative sites of clinically appropriate care.[17] Based on our research, it would also mean increasing the population in total cost of care, value-based arrangements from about 6 percent today to nearly 40 percent. We know from case examples that risk-bearing, value-based arrangements can materially improve cost of care as well as patient experience, but few, if any, of the effective models have been able to scale.[18]

— *Clinical productivity.* Over the past one to two decades, labor productivity in the US healthcare industry has declined; between 2001 and 2016, the industry contributed 9 percent of US economic growth but 29 percent of job growth. Previous McKinsey analysis has shown that if the healthcare delivery industry could rely more heavily on labor productivity gains than workforce expansion to meet demand growth, there is a potential savings opportunity of $160 billion to $310 billion. Importantly, many changes could be made within the existing workforce—and also help address the growing clinical staff shortage. There is significant unused capacity in physician schedules today; minor changes such as periodically "pruning" clinically inappropriate preference rules and broadening automatic reminder systems to reduce

[12] 2022 McKinsey Healthcare Stakeholder survey, July 1, 2022.
[13] *2022 Medicare Trustees report*, Centers for Medicare & Medicaid Services (CMS), November 30, 2020.
[14] Total public debt as percent of gross domestic product, Federal Reserve Bank of St. Louis, accessed September 6, 2022.
[15] Congressional Budget Office, accessed September 6, 2022.
[16] Risk to profit pools of $450 billion is less than the total potential impact of $590 billion because profit pools represent the private sector only. The additional $140 billion would be borne by Medicare and Medicaid fee-for-service costs (federal and state government funding).
[17] Estimate based on a McKinsey physician survey, claims analysis, and CMS National Health Expenditure data.
[18] Shubham Singhal, Mathangi Radha, and Nithya Vinjamoori, "The next frontier of care delivery in healthcare," McKinsey, March 24, 2022.

patient no-shows could contribute material gains. These types of changes could also lead to better access and quality of care, improved inpatient bed and operating-room capacity, and affordability improvements for consumers. Technology-enabled changes to clinical practice (noted below) would provide additional gains.[19]

— *Technology enablement.* Healthcare has lagged behind other industries in the application of new technologies, in part due to consumer reticence, the reluctance of highly trained clinicians, entrenched stakeholder interests, a complex regulatory framework, and the fragmented nature of the market. But we also know that progress in healthcare can be exponential when the right conditions for success exist. For example, in April 2020, during the COVID-19 pandemic, overall telehealth use for office visits and outpatient care was 78 times higher than it was in February of the same year.[20] Three critical technology-backed use cases offer a $250 billion to $350 billion savings opportunity: variability and waste reduction (for example, elimination of common low-value procedures), effective care delivery (for example, using connected devices and virtual care to promote disease management and avoid exacerbations), and more effective deployment of advanced AI, including in nonclinical functions. This opportunity is net of the cost required to develop and implement some of these transformative technologies.[21] (In our previous research, we identified nine technologies that could reshape healthcare, which can be organized into five key use cases.)

— *Administrative simplification.* Nearly a quarter of US national health expenditure goes toward administrative costs. Our analysis has shown that this could be reduced to about 18 percent through known interventions that can be applied either by individual organizations or by agreement and collaboration between organizations but without requiring industry-wide change. Examples include removing manual work for nursing managers through automated staffing and scheduling tools; building strategic payer–provider platforms to reduce demand by sharing information such as available in-network specialists; and automating repetitive work in human resources and finance. These known interventions all have a positive return on investment and could be deployed using current technology with nominal expense. The resulting system-wide savings would be $270 billion to $320 billion, and could also lead to materially improved employee, provider, and consumer experience.[22]

The headwinds for healthcare are significant and the risks for the industry are sizeable. But the size of the opportunity outstrips those challenges. Innovative models exist and, if scaled up, could deliver the $1 trillion improvement. The challenge for the industry is to scale up these innovative models at speed. Another article in this series, "The gathering storm: An opportunity for leaders to reorder the healthcare industry" outlines the approach industry leaders could adopt to capture these improvements.

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[19] Nikhil Sahni; Pooja Kumar, MD; Edward Levine; and Shubham Singhal, "The productivity imperative for healthcare delivery in the United States," McKinsey, February 27, 2019.
[20] Oleg Bestsennyy, Greg Gilbert, Alex Harris, and Jennifer Rost, "Telehealth: A quarter-trillion-dollar post-COVID-19 reality?" McKinsey, July 9, 2021.
[21] Shubham Singhal and Stephanie Carlton, "The era of exponential improvement in healthcare?," McKinsey, May 14, 2019.
[22] Nikhil R. Sahni, Prakriti Mishra, Brandon Carrus, and David M. Cutler, "Administrative simplification: How to save a quarter-trillion dollars in US healthcare," McKinsey, October 20, 2021.

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