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Future of US healthcare: Gathering storm 2.0 or a golden age?

Should healthcare leaders hunker down to weather the next gathering storm or reimagine their businesses through AI, automation, and innovative-care models? The best leaders will do both.

by Shubham Singhal, Drew Ungerman, and Jason Azzoparde with Tuhina Kapoor

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Healthcare industry economics continue to be roiled in the postpandemic era, and the outlook for funding suggests continuing relentless pressure. Healthcare industry EBITDA as a proportion of national health expenditure (NHE) was 200 basis points lower in 2024 compared with 2019. From 2024 through 2027, it is expected to fall another 100 basis points, with marginal recovery expected by 2028 through targeted interventions, according to McKinsey research.

Nonetheless, the potential opportunity from advances in AI, automation, efficient sites of care, medical science, and care model innovation is staggering. We estimate that the available improvement opportunity is 9 to 15 percent of NHE on a run-rate basis.[1]

As always, the opportunity to improve healthcare outweighs the headwinds if healthcare leaders can unlock the transformation required to seize the opportunity.

Gathering storm 2.0?

Healthcare is still reeling from the storm unleashed by the pandemic. Now it faces another gathering storm—one emerging from fundamental shifts in the macroeconomic landscape. The trade, economic, and security structures that emerged from the post–Cold War unipolar order are giving way to a multipolar world. Intensifying geostrategic competition is leading to higher defense spending[2] and a push to reverse the decline of the United States' share of global manufacturing value added, which fell from about 25 percent in 2000 to roughly 15 percent in 2024.[3] In addition, trade uncertainty is high,[4] with a push to contain the trade deficit, which has greatly expanded over the past half century. Concurrently, the US middle class has steadily eroded, and reversing this trend is a critical priority. Between 2000 and 2018, the middle-wage employment share declined 6 percent, and median wages grew just 1 percent annually, compared with 7 percent for low-wage earners and 5 percent for high-wage earners.[5] Simultaneously, the US federal deficit is poised to surpass $1.9 trillion in fiscal year 2025—a peacetime high—with interest costs on that debt edging closer to $1 trillion annually.[6]

These challenges portend a period of tectonic shifts in the trade, economic, and security order. Healthcare, despite being a domestic industry, sits squarely on the fault line of these shifts.

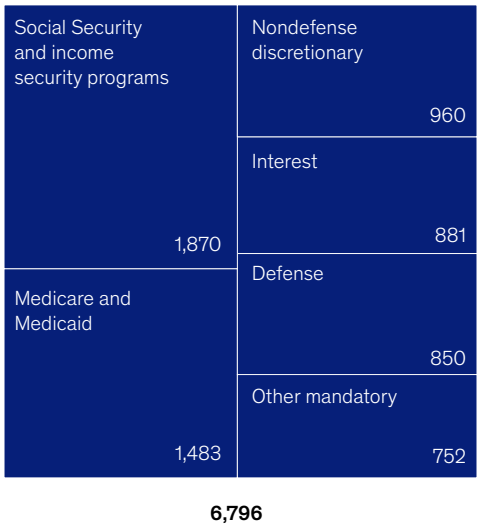
In 2024, the federal budget totaled $6.8 trillion, and the federal deficit was 6.4 percent of GDP (Exhibit 1). Most economists agree, however, that a sustainable level is below 3 percent.[7] However, recent NATO policies have introduced a new challenge: Member countries recently agreed to raise defense spending to 5 percent of GDP,[8] which for the United States would mean a two-percentage-point increase. If this policy had been in effect in 2024, the US deficit would have been 8.4 percent, further straining fiscal sustainability. With Medicare and Medicaid accounting for approximately 22 percent of the 2024 federal budget, healthcare is likely to face continued pressure as fiscal constraints tighten.

1 McKinsey Value Pools analysis (survey of 1,069 clinicians in 2021); CMS Limited Data Set Claims Data (2022), Centers for Medicare & Medicaid Services, accessed 2025; Merative MarketScan Commercial Claims Database (2022), Merative, accessed 2025; Sean P. Keehan et al., "National health expenditure projections, 2024–33: Despite insurance coverage declines, health to grow as share of GDP," *Health Affairs*, 2025, Volume 44, Number 7.
2 "Chart pack: Defense spending," Peter G. Peterson Foundation, July 2025.
3 "America let its military-industrial might wither. China's is booming," *Wall Street Journal*, May 29, 2025.
4 Economic Policy Uncertainty Index, Economic Policy Uncertainty, accessed September 9, 2025.
5 Based on data from the US Bureau of Labor Statistics, Occupational Employment Statistics, and McKinsey Global Institute analysis, courtesy of the McKinsey Geopolitics Practice.
6 "The budget and economic outlook: 2025 to 2035," Congressional Budget Office, January 17, 2024.
7 "The federal budget in fiscal year 2024: An infographic," Congressional Budget Office, March 20, 2025.
8 "Defence expenditures and NATO's 5% commitment," NATO, August 27, 2025.

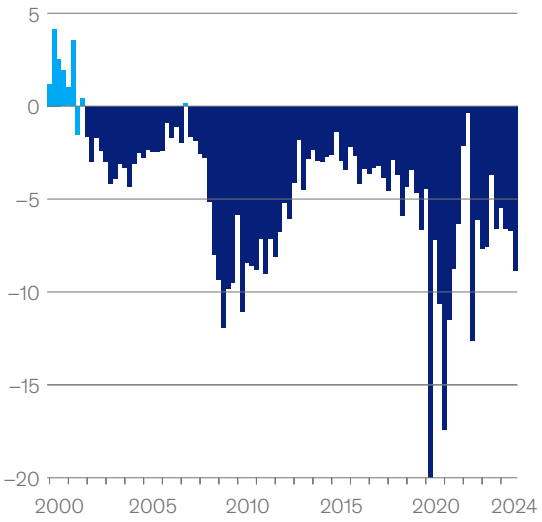
Exhibit 1

The US budget deficit is at an unsustainable level.

US budget, by sector, 2024, $ billion



Budget deficit as share of GDP, % (quarterly)



Source: Office of Management and Budget; "The federal budget in fiscal year 2024: An infographic," Congressional Budget Office, March 20, 2025; US Bureau of Economic Analysis; US Department of the Treasury; McKinsey analysis

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In fact, recent legislation and regulations have focused on curtailing healthcare spend. The recently enacted One Big Beautiful Bill Act (OBBBA), signed into law on July 4, 2025, could lower federal spending on healthcare by $1 trillion over a ten-year period.[9] The law includes a series of changes to government-subsidized health insurance that may reduce enrollment in Medicaid and Affordable Care Act (ACA) marketplaces.[10] The law also changes tax provisions for providers, with implications varying by state—reducing state provider taxes by freezing new taxes, disallowing tax increases, and phasing down the "safe harbor" threshold for existing provider taxes in Medicaid expansion states.[11] The new limits on provider taxes in states that have adopted the ACA expansion could lead to lower directed payments for providers.[12]

In addition to the impacts from recent legislation, a series of emerging policies could further reshape the financial outlook for healthcare stakeholders. For example, site-neutral payment policies under consideration at the federal level could trigger declines in net patient service revenue (NPSR), especially for hospital outpatient departments, which have historically received higher reimbursement rates than independent physician offices.[13] Additionally, expanded tariffs

[9] "Estimated budgetary effects of Public Law 119-21, to provide for reconciliation pursuant to Title II of H. Con. Res. 14, relative to CBO's January 2025 baseline," Congressional Budget Office, July 21, 2025.
[10] "Information concerning Medicaid-related provisions in Title IV of H.R. 1," Congressional Budget Office, June 24, 2025.
[11] "H.R.1 - 119th Congress (2025-2026): One Big Beautiful Bill Act," US Congress, July 4, 2025.
[12] "Which states might have to reduce provider taxes under the Senate reconciliation bill?," Kaiser Family Foundation, June 18, 2025.
[13] Klara K. Lou et al., "Medicare site-neutral payment policies: Effects of proposals on hospitals and beneficiary groups," *Health Affairs*, 2025, Volume 44, Number 6.

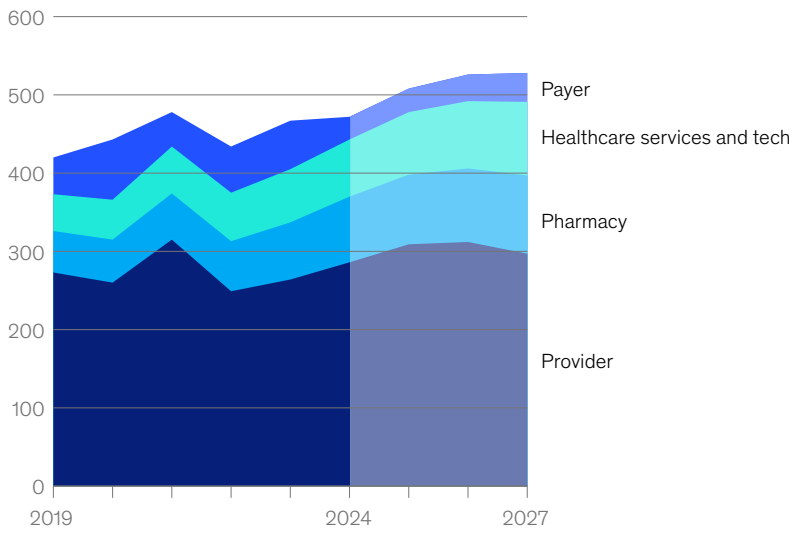
on imported goods—including medical devices, pharmaceuticals, and core supplies—could increase cost pressures across the healthcare supply chain, compounding the already-elevated inflationary trends.[14] Furthermore, proposed modifications to the 340B Drug Pricing Program could substantially reduce reimbursement rates for eligible providers.

This latest set of challenges comes after the pandemic-induced storm that hit the healthcare industry and greatly affected provider and, more recently, payer economics (Exhibit 2)—as documented in McKinsey's *The gathering storm in US healthcare* series. While the industry is in the midst of recovering from that economic downturn, the current macroeconomic environment, along with legislative, policy, and regulatory hurdles, portend a second gathering storm.

Exhibit 2

The US healthcare industry has experienced uneven performance over the past six years, with limited respite until 2027.

EBITDA distribution across healthcare segments, 2019–27, $ billion



Source: McKinsey Value Pools Model

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[14] Sean D. Sullivan et al., "The consequences of pharmaceutical tariffs in the United States," 2025, *Journal of Managed Care & Specialty Pharmacy*, Volume 31, Number 6.

Golden age?

The ideas for improving healthcare are not new, nor is the fact that the total opportunity available far exceeds the impact of the headwinds. What is new today is the impetus for change—the economic hit is both severe and multiyear, with no signs of relief from external funding. Change, however, has been exceedingly difficult in a large and complex healthcare industry.

Yet the conditions are favorable for a radical reimagination of the healthcare industry, particularly with the advent of AI and other automation technologies. The shortage of clinical labor means that the application of technology, AI, and other productivity-enhancing measures does not portend large-scale layoffs. Moreover, the strong growth in demand for healthcare services indicates that a restructuring does not mean an aggregate shrinking of the industry.

Together, these factors create an unprecedented window of opportunity to reimagine healthcare. We outline three of the most promising vectors: enhancing affordability and efficiency with AI and automation; making care patient centered through AI; and reshaping care models with specialty-led innovations and moving sites of care.

Improve affordability and productivity with AI and automation

The promise of AI to improve efficiency has long been anticipated. Now, with the advent of generative AI and advanced automation, that promise is expected to become truly actionable and scalable. While the vast majority of AI solutions have yet to generate direct monetary value, early applications are demonstrating measurable gains in productivity and decision-making. What was once theoretical is now augmenting clinical and administrative work, enhancing how care is developed, delivered, and financed. Across the ecosystem of providers, payers, and biopharma, AI is expected to unlock multibillion-dollar value pools and, over time, enable a new agentic workforce in which people and intelligent systems collaborate to manage workflows, decisions, and operations. Taken together, AI has the power to enhance patient affordability and productivity for the industry, which in turn can improve patient access, outcomes, and experiences at scale.

— *Providers.* Large and immediate opportunities for providers lie in automating high-burden administrative workflows such as prior authorizations, clinical documentation, and coding. Automation can also enhance diagnostic assessments, accelerate discharge planning, and optimize operating room utilization, reducing delays and increasing throughput. Beyond these functions, AI-enabled workforce management solutions can help reduce staff turnover, improve shift allocation, and boost productivity. Additional value can be gained through automation of corporate services (for example, finance, HR, and IT) and by strengthening supply chain resilience and cost efficiency, an area with direct bottom-line impact. We estimate that by using currently available technology, providers could see a gross uplift of 11 to 17 percent of NPSR.[15]

[15] McKinsey analysis based on expert interviews, case studies, and audited financial statements. Excludes Medicaid NPSR from consumer engagement and revenue cycle management domains and Medicare FFS (fee-for-service) revenue from pricing and contracting due to lack of applicability. Assumes Medicare FFS NPSR is approximately 50 percent of reported Medicare NPSR.

— *Payers.* AI and automation present a near-term opportunity for payers to tackle rising medical costs by transforming key care management functions. In utilization management, AI can accelerate prior authorization by evaluating case appropriateness and guiding care to lower-cost settings with comparable outcomes and do so with greater transparency. Additionally, predictive models can enhance case and disease management by enabling targeted outreach and timely interventions. AI could also improve network design through provider optimization, unit cost benchmarking, and smarter contracting. These levers together can trigger a gross reduction in medical costs of 5 to 11 percent. In parallel, AI can automate labor-intensive administrative functions, such as claims adjudication, prior authorization, member enrollment, and customer services. Taken together, these advances could improve accuracy and member experiences and lead to 13 to 25 percent in administrative savings. Moreover, these efficiencies can enable a 3 to 12 percent gross revenue boost with quality improvement, better member retention, and optimized plan design.[16] As capabilities mature, AI could help payers build more agile and intelligent operating models.

— *Biopharma.* Acceleration in the pipeline of new treatments has been underway for a few years now. AI is further accelerating this pipeline and is also promising to bring down development costs to enhance affordability. Early evidence suggests a boost in R&D productivity in both research and early discovery, as well as in the clinical development phases, with a more than 30 percent increase in initial drug target assessment, an approximately four- to ten-percentage-point increase in trial probability of success, and a roughly twofold increase in development speed.[17] Pharmaceutical companies could see a 30 to 50 percent reduction in the cost of clinical development in the long run (for example, data management, regulatory costs, and enrollment costs).[18]

Use AI to make healthcare delivery patient centered

Healthcare is no longer confined to the clinic. Instead, it happens continuously in patients' daily lives, given relatively new abilities to regularly measure and collect individualized data beyond the clinic. With the ability to collect and interpret real-time health data and generate tailored content through AI-powered assistants, providers and payers can now engage patients as an "n of 1." Generative AI enables the creation of dynamic, personalized health ecosystems. These systems can support healthy living and self-care, connect patients within social communities, adapt care delivery through tools such as remote monitoring and telehealth, and streamline financial access—for instance, easier payment systems.

Patients are beginning to embrace these possibilities. They see AI not just as a tool for efficiency but also as a companion in navigating their health journey—whether through answering questions about illnesses, guiding self-care for nonurgent needs, helping manage chronic conditions via biometric tracking, or offering supportive explanations of imaging and test results.[19] This shift holds real potential to meaningfully improve affordability, with adoption of the latest technologies, including AI, estimated to result in net savings of 5 to 10 percent of healthcare spending, according to a study coauthored by McKinsey and published by the National Bureau of Economic Research.[20] Importantly, harnessing AI can also build trust, empower patients, and enhance engagement between patients and the healthcare system. In a recent study, licensed clinicians rated about 78 percent of chatbot-generated medical responses

16 Shubham Singhal and Jessica Lamb, "The AI opportunity: How payers can capture it now," McKinsey, June 5, 2024.
17 "Generative AI in the pharmaceutical industry: Moving from hype to reality," McKinsey, January 9, 2024.
18 "Generative AI in the pharmaceutical industry: Moving from hype to reality," McKinsey, January 9, 2024.
19 McKinsey Consumer Health Insights Survey, May 2025, n = 3,034.
20 Nikhil Sahni, George Stein, Rodney Zemmel, and David M. Cutler, *The potential impact for artificial intelligence on healthcare spending*, National Bureau of Economic Research working paper, number 30857, October 2023.

to consumer questions as "good" or "very good." Compared with physicians' replies, gen AI medical responses were rated "empathetic" or "very empathetic" at a rate roughly 40 percentage points higher.[21]

Even in operational areas, the patient benefit is clear. When AI tools are integrated with scheduling platforms, they not only reduce no-shows but also redirect patients toward the right care settings. For example, in one study, 32 percent of patients who were originally headed for the emergency department chose less emergent care instead.[22] In another study, about 44 percent shifted away from same-day appointments, and roughly 46 percent of assessments happened outside clinic hours.[23] These changes translate into a more accessible, responsive, and patient-centered healthcare experience.

Transform care through specialty-led care models and shifts in sites of care

Besides harnessing AI, rethinking how and where care is delivered also holds substantial opportunity to improve affordability and outcomes. Emerging models such as redesigning specialty care for complex patients and shifting care to more cost-effective—while still safe—settings have shown meaningful reductions in total cost of care (TCOC) and strong potential for broader impact.[24] As these approaches mature, the next frontier is scaling what works by moving beyond pilots to systemwide transformation that benefits patients, payers, and providers.

Specialty-led care models. Despite accounting for nearly 40 percent of total medical spend, specialty care has been on the sidelines of value-based care (VBC). While VBC has gained traction in primary care, many high-cost specialties, such as behavioral health, cardiology, nephrology, oncology, orthopedics, and women's health, have seen limited adoption. Penetration remains low, with just 28 percent of nephrology patients and 20 percent of orthopedics patients covered by VBC models, for example, and even less than 5 percent in many other high-cost specialties.[25]

Despite low adoption, the promise of specialty-led models is real: An encouraging example can be found in the management of chronic kidney disease, which is built around multidisciplinary care teams supported by predictive analytics, frequent touchpoints, proactive care and education, and support for behavioral and social determinants of health. These models can achieve 15 to 40 percent lower hospital readmission rates, 20 to 50 percent lower rates of hospitalization, and a 1.5 to 2.5 times increase in patients started on end-stage kidney disease treatment with an optimal, prescheduled care plan (for instance, timely dialysis access or transplant evaluation, rather than in emergency situations).[26] From 2018 to 2023, patients in such high-intensity outpatient care model programs had a 14 percent lower risk-adjusted TCOC than those in less intense programs ($47,000 versus $54,000 per member per year).[27]

[21] John W. Ayers et al., "Comparing physician and artificial intelligence chatbot responses to patient questions posted to a public social media forum," *JAMA Internal Medicine*, 2023, Volume 183, Number 6.
[22] Aaron N. Winn et al., "Association of use of online symptom checkers with patients' plans for seeking care," *JAMA Network Open*, 2019, Volume 2, Number 12.
[23] Keith E. Morse et al., "Use characteristics and triage acuity of a digital symptom checker in a large integrated health system: Population-based descriptive study," *Journal Medical Internet Research*, 2020, Volume 22, Number 11.
[24] McKinsey value-based care domain analysis of a large commercially insured data set (2018–23) and Centers for Medicare & Medicaid Services and Medicare Fee-for-Service Parts A and B claims data.
[25] Amit Kunte, Neha Patel, Zahy Abou-Atme, and Andrew Flynn, "Specialty risk: The next frontier of value-based care," McKinsey, July 22, 2025.
[26] Impact metrics are self-reported by the companies (Monogram Health, Strive Health, Cricket Health, EvergreenHealth websites) and sourced from their publicly available websites, investor materials, or press releases.
[27] CMS Limited Data Set Claims Data (2022), Centers for Medicare & Medicaid Services, accessed 2025.

By leveraging networks of specialists and multidisciplinary teams, specialty-led care models can improve patient outcomes, reduce unnecessary utilization, and align financial incentives more effectively. For payers and providers, these models represent a high-potential path to improving patient outcomes, reducing avoidable utilization, and lowering TCOC at scale.

Shifts in sites of care. We have seen great strides in recent years in transitioning to more cost-effective and convenient sites of care. In-home care experienced an 8 percent annual revenue growth over the past three years.[28] Ambulatory capacity is also expanding, with more procedures moving to ambulatory surgery centers (ASCs) and more complex infused therapies delivered in ambulatory infusion centers and suites and in the home, enabled by minimally invasive techniques, advances in anesthesia, and broader payer coverage.[29] Even beyond specialty care, such as with vaccinations and imaging, we saw pharmacies administer about 65 percent of adult flu shots in the 2024 to 2025 season. Additionally, based on a survey of clinicians and healthcare executives assessing expected volume shifts by specialty, radiology was projected to see a 25-percentage-point decline in hospital-based imaging volume as procedures move toward ambulatory settings over time.[30]

We believe opportunity remains on the horizon. By moving care away from higher-cost hospital settings, these models can greatly reduce overall healthcare expenditures and enhance patient satisfaction by providing care in more convenient and comfortable settings. For example, our research finds that approximately 50 percent of hospital outpatient department surgical cases are eligible to be performed in ASCs. This transition is projected to spur 7 percent compound annual revenue growth for 2024 to 2029.[31] The success of these models is driven by advances in medical technology and changes in payer policies that encourage the use of more accessible care settings—for example, the Centers for Medicare & Medicaid Services (CMS) has proposed phasing out the inpatient-only list and adding 547 procedures and codes to the ASC-covered procedures list for fiscal year 2026.[32]

Shifting sites-of-care models have shown the potential to reduce TCOC by 8 to 10 percent or more.[33] The benefits are clear for both payers and providers: better access, lower costs, and improved patient satisfaction. This transition is already underway, with leading systems making large-scale bets on outpatient growth. Ascension and Tenet Healthcare, for instance, have been investing in this transition for several years. Tenet, through its United Surgical Partners International (USPI) subsidiary (acquired in 2015), has doubled down, investing more than $250 million annually, adding nearly 70 new ASCs in 2024, and planning for

[28] McKinsey Value Pools analysis (survey of 1,069 clinicians in 2021); CMS Limited Data Set Claims Data (2022), Centers for Medicare & Medicaid Services, accessed 2025; Merative MarketScan Commercial Claims Database (2022), Merative, accessed 2025.

[29] Steven Young, Brian Osman, and Fred E. Shapiro, "Safety considerations with the current ambulatory trends: More complicated procedures and more complicated patients," *Korean Journal of Anesthesiology*, 2023, Volume 76, Number 5.

[30] "Influenza vaccinations administered in pharmacies and physician medical offices*, adults, United States," Centers for Disease Control and Prevention, May 7, 2025; Nikhil Sahni et al., "Potential US health care savings based on clinician views of feasible site-of-care shifts," *JAMA Network Open*, 2024, Volume 7, Number 8.

[31] McKinsey value pools analysis (survey of 1,069 clinicians in 2021); CMS Limited Data Set Claims Data (2022), Centers for Medicare & Medicaid Services, accessed 2025; Merative MarketScan Commercial Claims Database (2022), Merative, accessed 2025.

[32] "CMS proposes bold reforms to modernize hospital payments, strengthen transparency, and put patients back in control," Centers for Medicare & Medicaid Services, July 15, 2025; "Calendar year 2026 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center Proposed Rule (CMS-1834-P)," Centers for Medicare & Medicaid Services, July 15, 2025.

[33] McKinsey value-based care domain analysis of a large commercially insured data set (2018–23) and Centers for Medicare & Medicaid Services and Medicare Fee-for-Service Parts A and B claims data.

another ten to 12 openings in 2025. Ascension recently announced its agreement to acquire Amsurg for $3.9 billion, expanding its ASC footprint from roughly 58 sites to more than 250 nationwide, signaling a step change in its care delivery model.[34] These moves underscore how both not-for-profit and for-profit systems are actively reshaping their portfolios to capture the cost, access, and patient satisfaction benefits of shifting appropriate portions of care away from hospital campuses.

The imperative to restructure and reimagine

Recently, we asked a healthcare CEO, "Is your agenda geared toward the gathering storm 2.0 or the golden age?" She responded, "Both!" The agenda for healthcare leaders indeed should cover both restructuring to brace for the gathering storm and reimagining to prepare for the golden age.

Restructure

During economic downturns or periods of disruption, organizations that get fit thrive. This part of the agenda involves three major elements:

— *Leaner cost structure.* Organizations need to act decisively to streamline operations, embed technology, and improve productivity. The goal is not incremental gains but transformative performance—by resetting cost structures and expanding margins sustainably.

— *Stronger balance sheet.* Leaders also need to shore up balance sheets through debt reduction, refinancing, and disciplined capital management, ensuring resilience in a volatile environment.

— *Streamlined business portfolio.* Organizations should divest assets that are either underperforming or no longer fit for purpose—whether because the market lacks attractiveness or because others are better owners or operators.

Reimagine

The second, more strategic part of the agenda is to reimagine the organization along the following two dimensions:

— *Reshape your business around productivity and affordability, patient centricity, and care model redesign.* Organizations need to take bold steps to harness AI, not simply as a tool but also as a catalyst for transformation. This starts with boosting affordability and productivity by embedding automation and AI into core operations, from administrative workflows to clinical decisions. Additionally, using AI to reimagine healthcare means putting patients at the center by personalizing engagement, streamlining access, and guiding healthier behaviors. Leaders also need to innovate how care is delivered, scaling specialty-led care models and shifting services to lower-cost, more convenient settings such as ambulatory platforms. Together, these moves have the power to redefine what the healthcare industry can achieve, unlocking new value, improving patient outcomes, and building a system that is not only resilient but also future proof.

[34] Shelby Grebbin, "Tenet Healthcare reports strong ASC growth, plans continued expansion in 2025," Ambulatory Surgery Center News, February 14, 2025.

— *Reorient the business portfolio toward segments with secular growth through acquisitions and partnerships.* Organizations should structure their portfolios around high-growth healthcare segments. These include nonacute and ambulatory care, healthcare services and technology, and specialty pharmacy. Each organization will need to carefully choose specific businesses in these arenas that provide synergy with its core business.

Pursuing upside opportunities is not easy when facing potentially existential downsides. Healthcare leaders will need to do both. To prepare for the future, leaders must role model the conviction that transformation is possible, communicate a distinct and tailored action plan for the organization, and frame the purpose of this journey around the possibility of ushering in a golden age of affordability, experience, quality, and health outcomes.

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