

Healthcare Practice

The next frontier of healthcare delivery

Ten big shifts will define the future of care delivery in the United States.

by Shubham Singhal, Nithya Vinjamoori, and Mathangi Radha



The realignment of the US healthcare system to better address the population’s chronic-disease burden has accelerated significantly in the past few years. This transformation manifests itself as a shift to the next frontier of care delivery, spurred by a combination of changes in consumer preferences, technology adoption, policy direction, reimbursement, and investor appetite.

In this article, we identify and discuss the ten big shifts that will affect the future of care delivery in the United States. Payers, providers, and policy makers should take stock of these shifts as they seek to provide the best care possible to the nation’s consumers. The future of care delivery is:

- patient-centric
- virtual
- ambulatory
- in the home

- value-based and risk-bearing
- driven by data and technology
- enabled by new medical technologies
- transparent and interoperable
- funded by private investors
- both fragmented and integrated

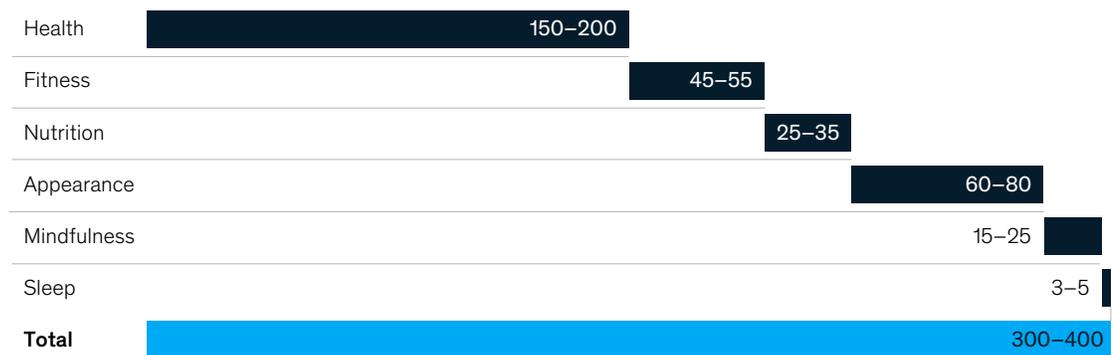
Patient-centric

We define “patient centricity” as a healthcare experience that is convenient, transparent, and personalized. Consumers expect to be treated as individuals with specific needs, not as problems to be solved. Indeed, US consumers are already taking steps to manage their own health and well-being, spending between \$300 billion and \$400 billion a year beyond qualified medical spending on goods and services they consider important to improving health (Exhibit 1).¹ US consumer spending on

Exhibit 1

US consumers spend \$300 billion to \$400 billion per year across six dimensions on goods and services they consider important to improving health.

US holistic health and wellness market, \$ billions¹



¹Figures may not sum, because of rounding.

Source: Shaun Callaghan, Martin Lösch, Anna Pione, and Warren Teichner, “Feeling good: The future of the \$1.5 trillion wellness market,” McKinsey, April 8, 2021; McKinsey Future of Wellness Survey (August 2020, n = 7,500); McKinsey Consumer Health Insights Survey (August 2021, n = 2,125); PatientPop

¹“National Health Expenditure Data,” Centers for Medicare & Medicaid Services, 2020.

wellness categories,² including fitness, nutrition, appearance, sleep, and mindfulness, is increasing: 30 to 40 percent of US consumers consider these categories to be a high priority (see sidebar “Categories of wellness spending”).³

Consumers are also demanding greater access to care and a more seamless experience. For example, more than 60 percent of consumers expect to be able to change or schedule a healthcare appointment, check medical records and test results, and renew a medication online.⁴ The expectation that healthcare information should be available at one’s fingertips has been rising with the ubiquity of mobile phones and has grown even more during the pandemic with the increase in virtual healthcare.

The economic case for patient-centric models is clear. Our recent surveys show that satisfied patients who use patient-centric models report having 36 percent fewer visits, are 28 percent less likely to switch providers, and are five to six times more likely to use other services from the same provider.⁵ While this cohort may be generally more involved in their healthcare, it is clear that satisfied patients feel more empowered to engage in their own health and feel as though they are getting better care, leading to improved outcomes overall.

Private investors are spurring much of today’s innovation around patient-centric models. Digital healthcare start-ups, differentiated by their patient-centric models, are gaining traction with venture funds. Venture funds invested more than \$29 billion in digital healthcare start-ups in 2021—more than double the level of investment in 2020.⁶ Consumer preference and the ROI for patient-centric models have become clearer, but the challenge is now one of scale.

Categories of wellness spending

Consumer spending on wellness falls into several categories:

- **fitness:** home gym equipment and fitness classes
- **nutrition:** vitamins and nutrition supplements
- **appearance:** beauty and skincare products, “athleisure” clothing, and nonsurgical aesthetic procedures
- **mindfulness:** meditation apps or courses
- **sleep:** app-enabled sleep trackers and melatonin or sleep-enhancing supplements

Virtual

Virtual health comprises services such as telehealth, digital therapeutics, digital pharmacy management, and remote patient monitoring. Virtual health has experienced substantial growth during the pandemic. Even as in-person health services return to normal levels, the level of telehealth visits in October 2021 remained more than 1,300 percent higher than before the pandemic (Exhibit 2).⁷ Behavioral health, for example, experienced a strong shift toward virtual visits during the early stages of the COVID-19 pandemic and continues to see a higher proportion of visits delivered virtually than prepandemic (Exhibit 3).

²Shaun Callaghan, Martin Lösch, Anna Pione, and Warren Teichner, “Feeling good: The future of the \$1.5 trillion wellness market,” McKinsey, April 8, 2021.

³2021 McKinsey Consumer Health Insights Survey (August 2021, n = 2,125); McKinsey Future of Wellness Survey (August 2020, n = 7,500).

⁴2021 McKinsey Provider Customer Experience Survey (n = 3,311).

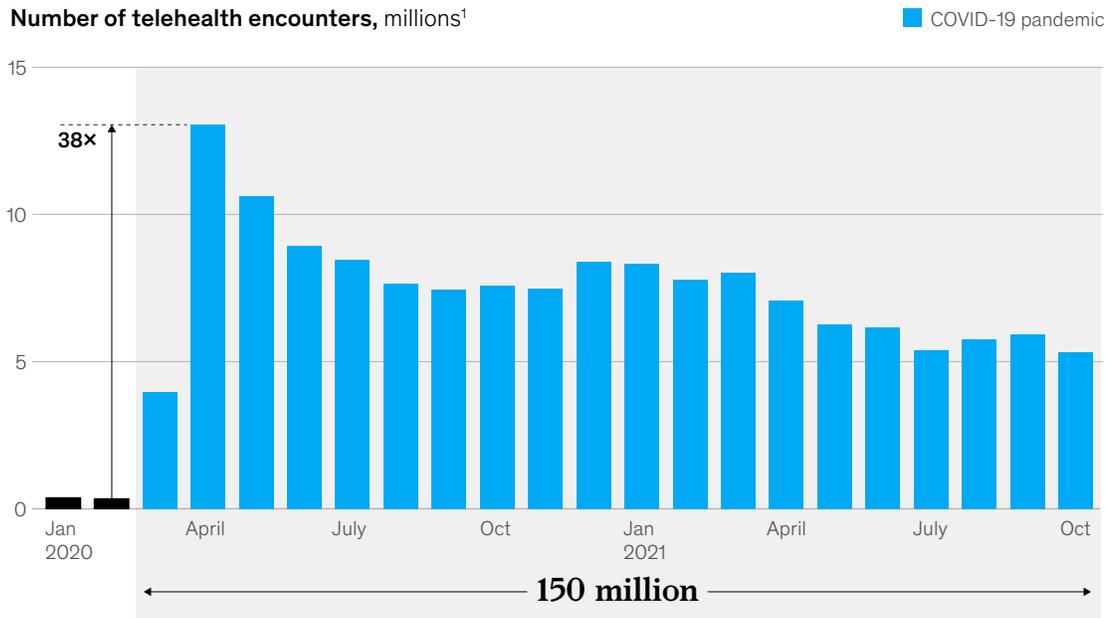
⁵Ibid.

⁶Bill Evans, Adriana Krasniansky, and Megan Zweig, “2021 year-end digital health funding: Seismic shifts beneath the surface,” Rock Health, January 10, 2022.

⁷Compile Health database, accessed March 9, 2022.

Exhibit 2

Virtual health visits grew 38-fold early on in the COVID-19 pandemic.



¹Includes evaluation and management visits only; excludes emergency-department, hospital inpatient, and psychiatry inpatient claims; excludes certain low-volume specialties; extrapolated to the commercial market. Source: Compile Health database; McKinsey analysis

The past two years have shown the potential of virtual care to spur innovation in healthcare delivery. Virtual care provides convenient and timely access to healthcare and holds the promise of reimagined care pathways. Favorable consumer perception and ongoing investment are likely to drive continued long-term growth of virtual health. In a previous article, we estimated that about \$250 billion in outpatient spending could shift to virtual settings.⁹ Much of this value lies in going beyond urgent care to more advanced care, including primary and specialty care and diagnostics and monitoring (Exhibit 4). The potential for savings is substantially higher for virtual models in acute care—including tele-intensive care units—and for those that are combined with models such as remote patient monitoring and hospital-at-home

programs. While the initial opportunity is aimed at enhancing convenience and access for patients, we see the potential for virtual care to improve cost and outcomes with further innovation.

Virtual models could revolutionize care delivery. As these models become more prevalent, healthcare leaders should ensure that their approaches are patient-centric and do not unintentionally worsen health inequities⁹ (for example, by missing opportunities to provide access to care for communities that do not have broadband or by inadvertently failing to meet the needs of minority, non-English-speaking, or disabled populations). Providers should also put guardrails in place to mitigate the risks of overdiagnosing or overprescribing in a virtual-care model.¹⁰

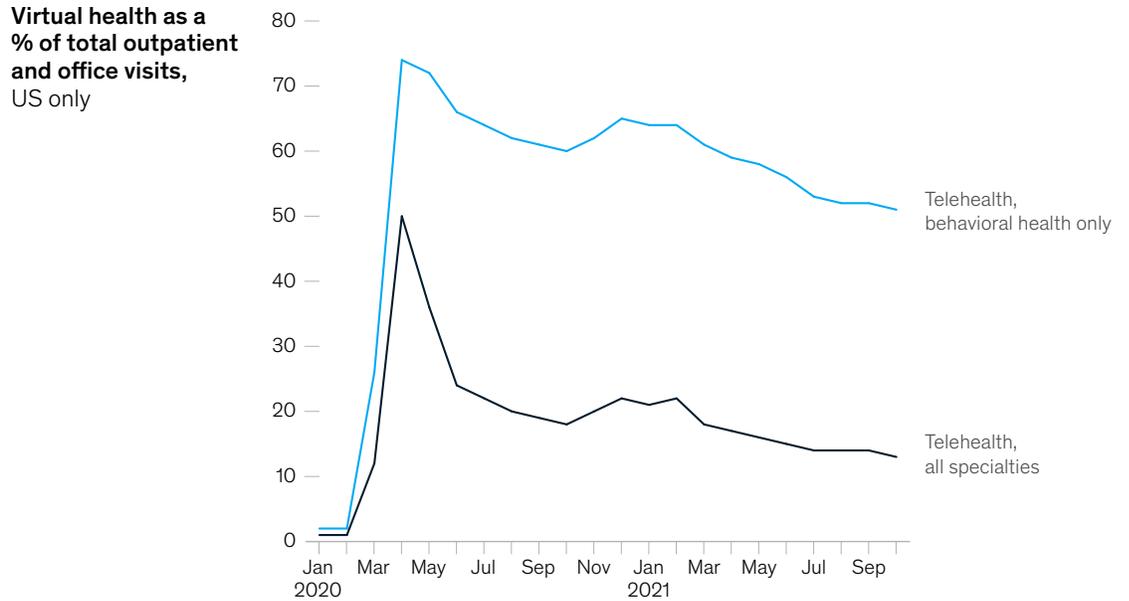
⁸Oleg Bestsennyy, Greg Gilbert, Alex Harris, and Jennifer Rost, "Telehealth: A quarter-trillion-dollar post-COVID-19 reality?," McKinsey, July 9, 2021.

⁹Jesse Bradford, Erica Coe, Kana Enomoto, and Matt White, "COVID-19 and rural communities: Protecting rural lives and health," McKinsey, March 10, 2021.

¹⁰Judith Garber, "Could telehealth increase inappropriate prescribing?," Lown Institute, November 17, 2020.

Exhibit 3

There has been a sustained shift of behavioral health services to telehealth-based delivery during COVID-19.



Source: Compile Health database, 2020–21

Finally, leaders should monitor regulatory action regarding the future of telehealth. During the pandemic, the US Centers for Medicare & Medicaid Services (CMS) facilitated the use of telehealth by temporarily waiving rules requiring clinicians to hold a valid license in the state where their patient was located. Some states are rolling back these waivers, creating potential headwinds for the use of virtual health. In addition, according to our latest research, physicians indicate a preference for seeing patients in their clinics¹¹—though many consumers remain enthusiastic about using virtual care.¹²

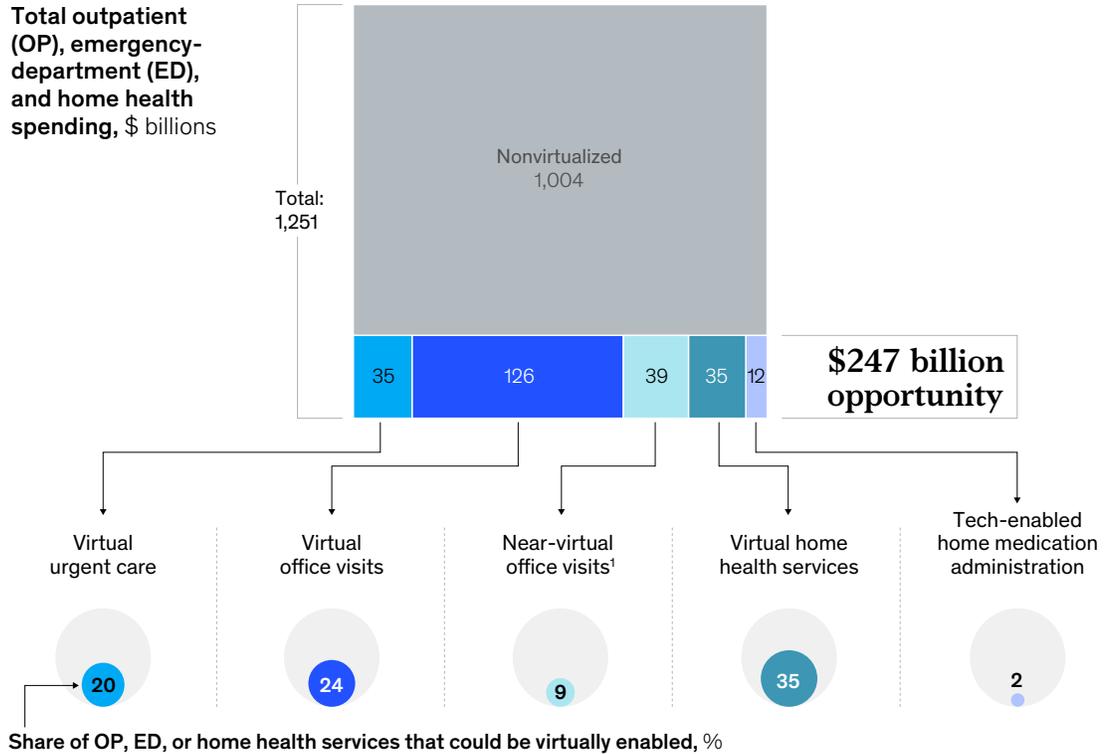
Ambulatory

The growing segment of ambulatory care accounts for one-third of provider revenue (about \$750 billion) in the United States.¹³ Several providers are embedded within ambulatory care, including physician practices, outpatient behavioral-health centers, ambulatory surgery centers, and urgent-care centers. Studies have shown that ambulatory care settings may offer advantages for patients when appropriate. One such advantage is shorter average visit length—25 percent shorter for ambulatory care services than comparable hospital outpatient visits. Also, there were lower complication rates, such as 1.1 percent total hip arthroplasty complication rates in ambulatory care

¹¹ Jenny Cordina, Jennifer Fowkes, Rupal Malani, and Laura Medford-Davis, “Patients love telehealth—physicians are not so sure,” McKinsey, February 22, 2022.
¹² Jenny Cordina, Eric Levin, Andrew Ramish, and Nikhil Seshan, “How COVID-19 has changed the way US consumers think about healthcare,” McKinsey, June 4, 2021.
¹³ McKinsey Profit Pools model, 2021.

Exhibit 4

Around 20 percent of all Medicare, Medicaid, and commercial outpatient, emergency-department, and home health spending could be virtually enabled.



¹Near-virtual office visits are services that require lab tests or diagnostics, with a portion of the visit requiring in-person interaction (for example, a blood draw), but the consultation with the physician or the review of the lab test results is virtual.
Source: McKinsey analysis

services compared with 5.2 percent in hospital outpatient departments.¹⁴

While inpatient hospital stays remain important for complex situations, the types of care that can be delivered safely in outpatient ambulatory settings are expanding. In a recent rule, CMS removed 255 of the 267 codes that were added to its Ambulatory Surgical Center Covered Procedure List (ASC CPL) in 2021. This was due to concerns that the codes

were put in place prematurely, as these codes still typically involve stays or active medical monitoring that spans overnight. However, in the same rule, CMS indicated that it expected to “continue to expand the ASC CPL in future years.”¹⁵ Such expansion could accelerate the shift to ambulatory outpatient settings. Overall provider profit pools reflect the shift, as the general acute care setting faces continued margin pressure, while ambulatory

¹⁴ Jonathan B. Imran et al., “Analysis of operating room efficiency between a hospital-owned ambulatory surgical center and hospital outpatient department,” *American Journal of Surgery*, November 2019, Volume 218, Number 5; Kathleen Carey et al., “Patient outcomes following total joint replacement surgery: A comparison of hospitals and ambulatory surgery centers,” *Journal of Arthroplasty*, January 2020, Volume 35, Number 1.

¹⁵ US Centers for Medicare & Medicaid Services, “Medicare program: Hospital outpatient prospective payment and ambulatory surgical center payment systems and quality reporting programs; price transparency of hospital standard charges; radiation oncology model,” *Federal Register*, November 16, 2021, Volume 86, Number 218.

outpatient settings are expected to grow more than 5 percent a year from 2021 to 2025.¹⁶

Despite the anticipated growth, ambulatory care remains a fragmented part of the patient journey, with different providers managing each type of service with minimal coordination. In addition, as we wrote in a previous article, there are significant variations in the penetration of ambulatory care across regions and specialties.¹⁷

Looking ahead, there will be continued opportunities for health systems, stand-alone operators, and investors to build ambulatory sites of care across varied specialty areas. Also, integrating and managing transitions of care will be increasingly important for ambulatory care. We will likely see greater consolidation and coordination among providers, with an uptake of technology and analytics to knit together the various services across the ambulatory continuum.

In the home

Opportunities for in-home care are expanding to different patient profiles and types of care. As we noted in an earlier article,¹⁸ more commoditized services, such as traditional post-acute home health and personal-care services, still make up about two-thirds of market revenue (\$75 billion to \$85 billion in 2019).¹⁹ However, some emerging home-care segments, including infusions, dialysis, primary care, and hospital-at-home models, are growing rapidly. These segments are more complex and technology-

enabled than traditional post-acute home health. In many cases, these are areas in which the capability to scale is still nascent.

We estimate that over the next three years, Medicare beneficiaries could see three to four times more care in their homes if relevant capabilities continue to develop into at-scale offerings.²⁰ That would translate into projected incremental Medicare spending of \$265 billion or more on care potentially delivered in the home in 2025 (Exhibit 5).

Delivering complex in-home care will require more specialized resources and skilled healthcare workers. Yet this hasn't deterred innovators from moving into sophisticated, emerging segments such as hospital-at-home care. There is a substantial amount of expected value in these capabilities, buoyed by regulatory and reimbursement support, because a growing body of evidence shows that the home can be a high-quality site of care. This follows a pattern of regulatory guidance during the pandemic facilitating innovation in many other types of home care, such as reimbursement for remote patient monitoring,²¹ increased coverage for telehealth services,²² and the expansion of hospital-at-home models.²³

The challenge of stitching together multiple modalities of care to build a cohesive patient journey remains an opportunity for innovators (see sidebar "Shifting the traditional patient journey"). If done correctly, integrating the many pieces of the patient journey—and making smart use of technology to do so—could create value for patients by supporting

¹⁶ McKinsey Profit Pools model, 2021.

¹⁷ Pooja Kumar and Ramya Parthasarathy, "Walking out of the hospital: The continued rise of ambulatory care and how to take advantage of it," McKinsey, September 18, 2020.

¹⁸ Dalglish Chew, Aneesh Krishna, Michael Morley, and Nithya Vinjamoori, "How 'Care at Home' ecosystems can reshape the way health systems envision patient care," McKinsey, February 2, 2022.

¹⁹ McKinsey Profit Pools model, 2021.

²⁰ Oleg Bestsenny, Michelle Chmielewski, Anne Koffel, and Amit Shah, "From facility to home: How healthcare could shift by 2025," McKinsey, February 1, 2022.

²¹ Eric Wicklund, "CMS expands remote patient monitoring coverage in proposed 2022 PFS," mHealth Intelligence, July 19, 2021.

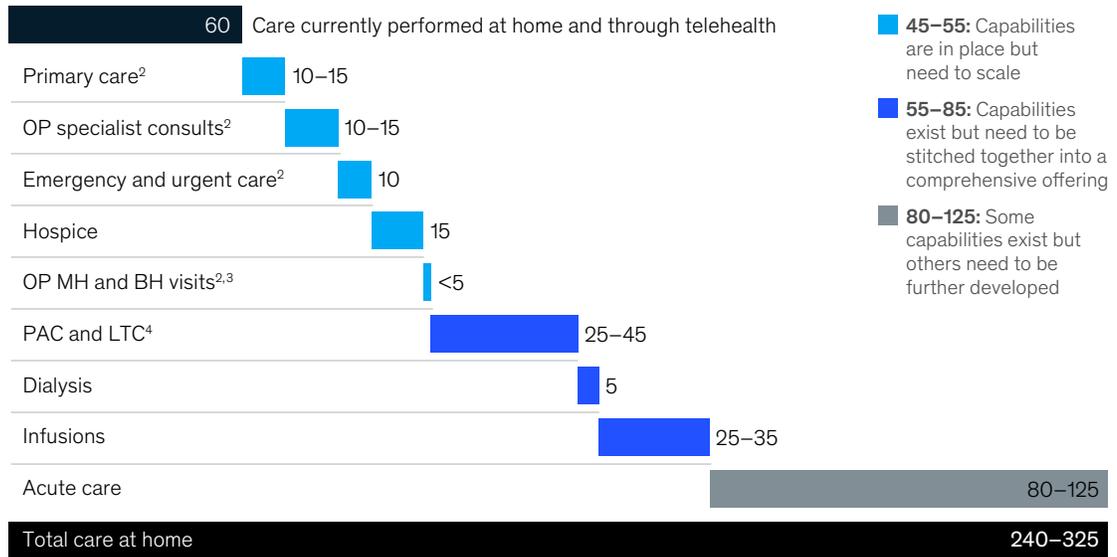
²² "Medicare telemedicine health care provider fact sheet," Centers for Medicare & Medicaid Services, March 17, 2020.

²³ "CMS announces comprehensive strategy to enhance hospital capacity amid COVID-19 surge," Centers for Medicare & Medicaid Services, November 25, 2020.

Exhibit 5

Medicare beneficiaries could see approximately three to four times more at-home care by 2025.

Medicare spend on services that could be performed at home by 2025,¹ \$ billions



¹ Rounded to the nearest 5 billion; 2025 spend based on national health expenditure (NHE) projections for Medicare annual growth rates.

² Categories have experienced significant growth in use of telemedicine and care at home due to the COVID-19 pandemic.

³ Outpatient mental health, and behavioral health.

⁴ Post-acute care and long-term care.

Source: 2018 Medicare claims data (Medicare limited data set files); NHE-projected Medicare annual growth rates

the delivery of better health outcomes in an easier-to-navigate manner.

Value-based and risk-bearing

The use of value-based models continues to grow.²⁴ We expect the proportion of the insured population in “at risk” contracts to increase rapidly: 10 percent annually from 2021 to 2025, compared with the 1 percent growth of the overall insured population over the same period. The shift to value-based care

is evident across various care model segments (Exhibit 6) and payer types (Exhibit 7). Management services organizations (MSOs), which can support the shift to these models by offering technology and administrative services for providers seeking to take on risk, are projected to grow rapidly over the next few years. MSOs could account for 9 percent of total insured lives by 2025, up from 5 percent today.²⁵ The situation is similar for capitated-risk staff or employed-risk models, although these account for the smallest segment of at-risk models.²⁶

²⁴ Value-based care (also known as risk-bearing models) is a healthcare payment model in which providers are paid based on patient outcomes and the quality of care provided. By contrast, a fee-for-service model—the predominant approach in the United States—is one in which providers are paid based on the amount of healthcare services they deliver.

²⁵ Based on data from the American Hospital Association, Medicare Limited Data Set Files (LDS), and Truven Health Analytics, analyzed through McKinsey’s proprietary Enrollment Projection Tool.

²⁶ These are providers (typically primary care physicians but could also include specialists) who are employed by the risk-bearing entity and intensively manage care for patient populations.

Shifting the traditional patient journey

To illustrate how a traditional patient journey could shift through the support of virtual, ambulatory, and home-based models, consider a pregnancy care journey (exhibit).

Prenatal vitamin prescriptions could be filled online and mailed directly to the home. Virtual visits could replace in-office visits for more urgent but nonacute questions. Providers could conduct examinations (one per trimester at a minimum) to monitor fetal growth in the

home using portable ultrasound devices. Wearables and monitoring devices (for example, continuous glucose monitors for patients with gestational diabetes) could transmit data to providers for more proactive monitoring, especially for higher-risk patients.

Home delivery opportunities for low-risk patients who wish to give birth at home could be further expanded given recent advancements in remote patient monitoring to augment in-person care

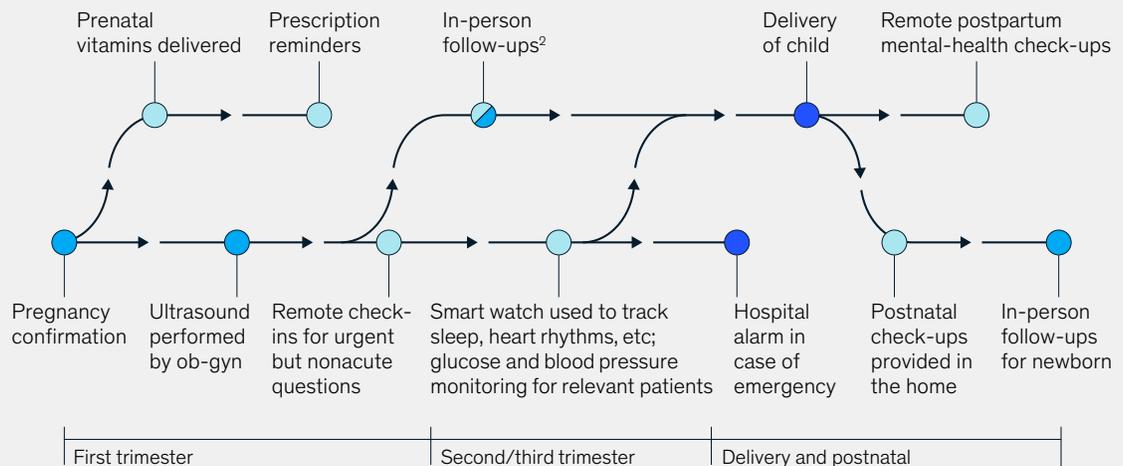
(assuming robust clinical and data-driven assessment and contingencies are in place). Post birth, physicians and other practitioners—such as lactation specialists, doulas, or behavioral-health specialists—could conduct more frequent check-ups in the home. The option of in-house check-ins could ease the burden of new parents who are balancing the care of a newborn with managing their own health.

Exhibit

Traditional patient journeys can be shifted fundamentally through support of virtual, ambulatory, and home-based models.

Pregnancy journey, illustrative

Setting: ○ Virtual/home ● Office/ASC¹ ● Hospital



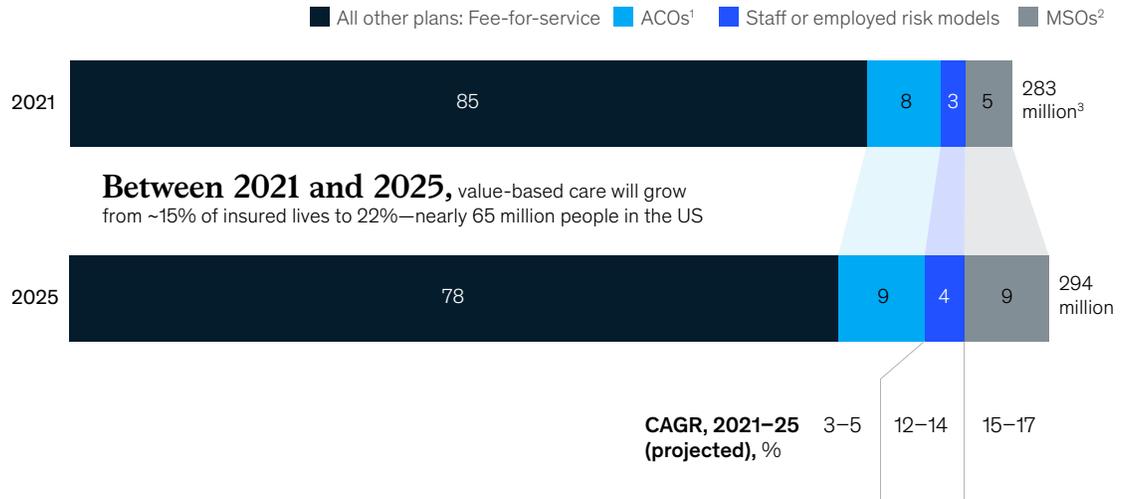
¹Ambulatory surgery center.

²Any acute changes or changes in the patient's condition may require additional hospital visits.

Exhibit 6

In terms of care models, the shift to value-based care will be substantial over the next few years.

Total US insured lives by physician reimbursement arrangement, % of all plan types



Note: Figures may not sum, because of rounding.
¹Accountable care organizations.
²Management service organizations.
³Does not include 7.5 million people with other government insurance or 29.1 million people without insurance.
 Source: American Heart Association; Enrollment Projection Tool; expert interviews; Medicare limited data set; Truven Health Analytics

Accountable care organizations²⁷ are also expected to grow at a steady pace through 2025. Overall, between 2021 and 2025, value-based contracts are projected to increase from about 15 percent of insured lives to 22 percent, covering nearly 65 million people in the United States.²⁸

Value-based models are most prevalent in primary care, but specialties are also seeing increasing activity. Within the specialty segment, orthopedics has experienced one of the highest adoption rates of value-based care. In orthopedics, an estimated 65 to 75 percent of spending is tied to risk-based models²⁹ such as bundled payments for care improvement, shared savings, pay for performance,

and capitation. Other specialty segments are starting to pursue value-based care, including women’s health and nephrology.

There is broad support for risk-based models, influenced by the fact that risk-bearing providers have demonstrated superior outcomes at lower costs. For example, fully capitated primary care providers have demonstrated total cost-of-care savings of 10 to 15 percent³⁰ over traditional fee-for-service providers for high-risk populations.³¹

The valuation of risk-bearing models is substantial: value-based care players that received investment in 2020 have an implied total valuation of \$40 billion

²⁷ Accountable care organizations (ACOs) are groups of doctors, hospitals, and other healthcare providers that come together voluntarily to give coordinated care to Medicare patients.
²⁸ Based on data from the American Hospital Association, Medicare Limited Data Set Files (LDS), and Truven Health Analytics, analyzed through McKinsey’s proprietary Enrollment Projection Tool.
²⁹ Expert interviews with payers, providers, and Medicaid specialists.
³⁰ McKinsey analysis of provider risk-bearing models in primary care.
³¹ “High-risk populations” are typically defined as Medicare Advantage or dual (receiving both Medicare and Medicaid) populations with risk scores above 1.8.

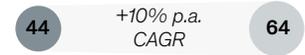
Exhibit 7

For payers, the shift to value-based care will be substantial over the next few years.

Total insured population, 2021 vs 2025, millions



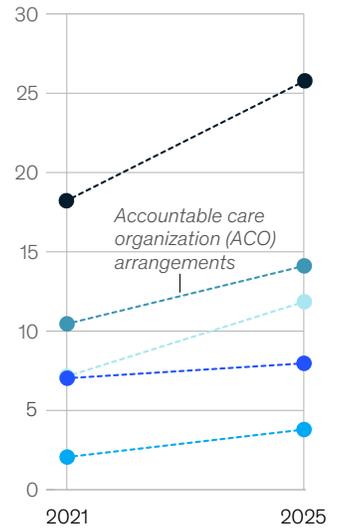
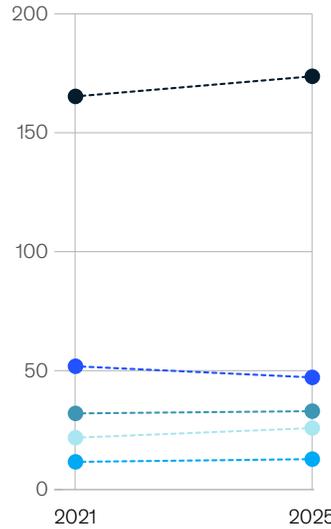
Lives within 'at risk' contracts,⁴ 2021 vs 2025, millions



Insured population, by category, millions

Provider-led health plans may overlap with other value-based care categories.

- --- Commercial
- --- Duals²
- --- Managed Medicaid
- --- Medicare Advantage
- --- Medicare FFS³



Note: Value-based care (VBC) refers to a spectrum of reimbursement models from shared savings, bonus payments, and upside and downside risk models to capitation. ¹ Per annum. ² Dual-eligible individuals: people enrolled in both Medicare and Medicaid. ³ Fee-for-service. ⁴ For delegated lives, the assumption is that hospital lives largely do not overlap with other categories. Source: American Heart Association; expert interviews; InterStudy and diagnosis-related group enrollment data; Medicare limited data set; McKinsey insurance enrollment projection model; Truven Health Analytics

by 2025.³² While several healthcare companies built around value-based principles saw their stock price deflate in the 12 months from March 2021 to March 2022, this may reflect the uncertainty around the ability of these organizations to scale to achieve their aspirations based on their current capabilities—capabilities that may improve over time, especially regarding physician engagement and technology and analytics. In contrast, valuations of those

organizations with proven models and with positive profitability did not experience a dip.

Driven by data and technology

Generally, new technologies have increased costs in healthcare rather than reduced them. But that trend may shift as technologies improve and become more useful for helping healthcare innovations

³²Based on valuation data from Preqin, Crunchbase, and publicly available news reports. The total is the summed valuation of Agilon, Aledade, Best Value, Cano Health, Iora, MBMG, Oak Street, P3, and VillageMD. The weighted average is between the public-market rate of 7 percent and the private-equity rate of return of 18 percent.

to scale. As mentioned in a previous article, if the industry could rely more on labor productivity gains than workforce expansion to meet demand growth, by 2028, spending could be about \$280 billion to \$550 billion less than current health expenditure projections.³³ Continued improvements to care delivery technologies will no doubt play a role in capturing productivity gains.

Technology will enable the next frontier of care delivery in several ways. Care can be more virtualized, through advances in electronic medical records and telehealth capabilities. Care can be more closely linked to value, as data become more available in the workflow at the time of the physician encounter. Care can be more personalized, as analytics and insights deliver the right messages to the right patients at the right time. Finally, care can be seamlessly transmitted, by integrating capabilities across the patient experience. For example, many physicians spend a significant portion of their day updating medical data. One study found that physicians spend 49 percent of their total time and 37 percent of their time with patients in the examination room working on electronic health records and desk work.³⁴ Easier-to-use technologies could give physicians more time with their patients and colleagues.

Another example of technology-driven improvement of care delivery is automatic appointment reminders.³⁵ By helping patients to remember to attend appointments, these reminders could both improve care outcomes for the patient (by reducing delays and skipped care) and increase the efficiency of physician utilization (by reducing unexpected gaps in the appointment schedule).

Enabled by new medical technologies

Medical technologies are facilitating innovation in patient care in three ways. First, new products and

services are creating self-service opportunities that can also reduce the number of patient touchpoints needed to deliver care. Products such as wearables to track blood sugar levels in patients with risk factors for diabetes are still not widely used but could soon enable many opportunities for self-service, such as continuous care for chronic-condition management. Similarly, technologies such as remote patient monitoring, home telemetry, and robotic technologies are supporting the blending of automated, virtual, and home-based care delivery, which could extend the time between clinical touchpoints by equipping patients with the data-tracking and alerting tools needed to prevent acute episodes.

Second, new medical technologies are aiding the shift to lower-acuity sites of care. For example, medical wearables can help detect health issues earlier and may prevent hospitalizations. And joint-replacement surgery robots that have been approved for use for certain procedures in ambulatory surgery centers can improve and lower variances in surgical outcomes, increasing the odds of avoiding inpatient care.

Third, new medical technologies are also helping to reduce care delivery costs (Exhibit 8). For example, clinicians can use cardiac monitoring patches to identify arrhythmias for about 90 percent less cost than an implantable loop recorder.³⁶

Transparent and interoperable

As recent regulatory changes take effect, we are seeing the first wave of industry responses to improve transparency and data sharing. Three themes are emerging: price transparency, data interoperability, and data access.

Improved price transparency has been on the regulatory agenda for years, but negotiated-rate information is finally becoming available. Since

³³ Pooja Kumar, Edward Levine, Nikhil Sahni, and Shubham Singhal, "The productivity imperative for healthcare delivery in the United States," McKinsey, February 27, 2019.

³⁴ Christine Sinsky et al., "Allocation of physician time in ambulatory practice: A time and motion study in 4 specialties," *Annals of Internal Medicine*, December 2016, Volume 165, Number 11.

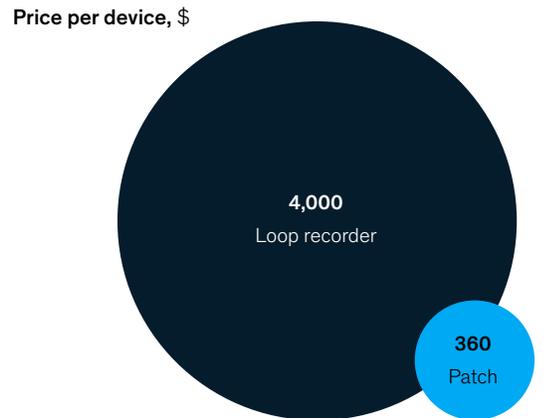
³⁵ "The productivity imperative," February 27, 2019.

³⁶ Meg Tirrell, "A tiny patch powering big data is changing the way we monitor heartbeats," CNBC, January 30, 2017.

Exhibit 8

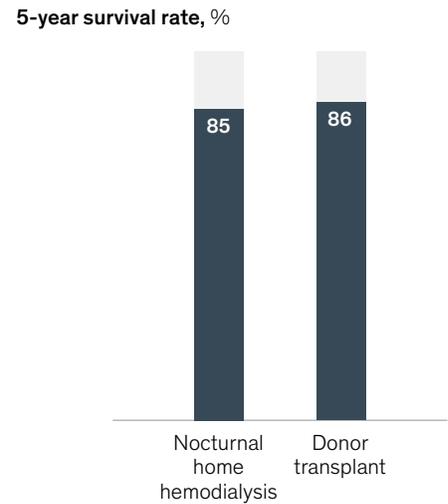
New technologies are improving cost and outcomes without increasing the intensity of the care patients experience.

Cardiac monitoring patches are a noninvasive, lower-cost way to identify arrhythmias



Source: CNBC; Expert interviews; Nephrology Dialysis Transplantation, 2009

Home dialysis enables comparable outcomes to transplantation through more frequent, extended dialysis



hospitals began publishing rate information in January 2020, about 70 percent of hospitals (based on a review of about 320 providers) have published some form of negotiated rate by payer.³⁷ In 2022, another wave of negotiated-rate information will become available—this time from payers.³⁸ By the end of 2022, consumers will likely be able to use this negotiated-rate information more readily through cost-sharing calculator tools that payers are required to provide. Increased transparency could result in changes to competitive dynamics throughout the industry. For example, hospitals could use newly available rate data from their competitors to shape negotiations with payers. Similarly, payers will have information about what

their competitors have negotiated with hospitals in a particular region. The integration of price and quality-rating information could affect consumer decisions about where to go for care.

Interoperability³⁹ rules went into effect in 2021.⁴⁰ These include prohibitions on data blocking among providers: CMS-regulated payers must make encounter and claims data available to members via publicly accessible APIs. At the end of 2022, new requirements for vendors of electronic health records will take effect⁴¹ that will make structured data—including clinical components—available to both consumers and third parties. As a result, providers and technology companies will be able to

³⁷ Based on a sample of about 320 hospitals in large US markets.

³⁸ "FAQs on payer-to-payer data exchange," Centers for Medicare & Medicaid Services, accessed March 16, 2022.

³⁹ "Interoperability" is defined by the Office of the National Coordinator for Health Information Technology as "the ability of two or more systems to exchange health information and use the information once it is received." For more, see "The path to interoperability," Office of the National Coordinator for Health Information Technology, September 2013.

⁴⁰ "Policies and technology for interoperability and burden reduction," Centers for Medicare & Medicaid Services, updated December 9, 2021.

⁴¹ "ONC's Cures Act Final Rule highlighted regulatory dates," Office of the National Coordinator for Health Information Technology, accessed March 16, 2022.

access these structured data, potentially helping them to make strategic and investment decisions in competitive markets.

Finally, more Medicare and Medicaid claims data from CMS are available than ever. When we combine the size of these data sets with trends in price transparency and interoperability, we see a path forward to a better understanding of care utilization and cost trends for patients.

Funded by private investors

Private investment in healthcare has evolved thematically over the past decade. For much of the 2010s, investors focused on consolidation of healthcare assets and optimization of back-end functions.⁴² Beginning around 2018, business model expansion plays became more popular, reflected in investments in platform models and the integration of ancillary offerings.⁴³ Looking ahead, we expect

significant investment in care delivery innovation, including redesigning the patient journey through digital enablement, shifting care into ambulatory and home settings, and expanding value-based care models.

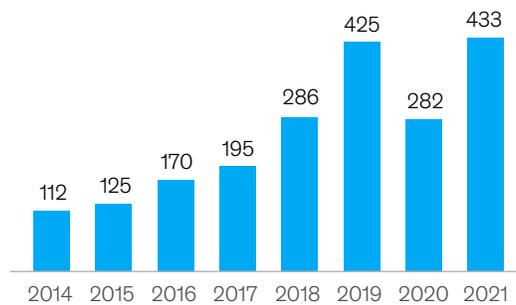
Private-equity deal volume in healthcare is outpacing the overall US industry average. Healthcare private-equity and venture capital deal volume grew at a 22 percent annualized rate from 2014 to 2021, compared with only about 2 percent for all private investment deals (Exhibit 9).⁴⁴

It's important to consider the investment emphasis on care delivery innovation in the broader context of US private investment. Excess capital for US-based funds has nearly doubled in five years, from \$700 billion in 2016 to \$1.3 trillion in 2021.⁴⁵ Healthcare remains a top-three investment area, with more than 10 percent of committed funds in 2021 earmarked for healthcare.⁴⁶

Exhibit 9

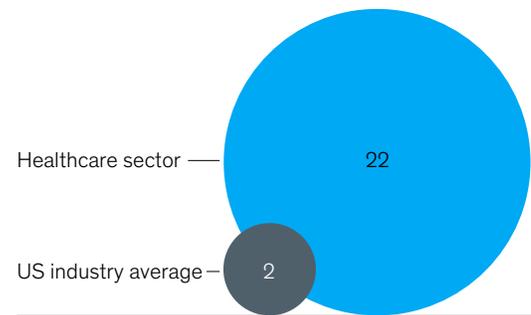
Investment activity within healthcare services has been robust.

US healthcare private-equity (PE) and venture capital (VC) deals, total per year



Source: Dealogic; Irving Levin Associates; S&P Capital IQ

PE and VC deal growth, 2014–21, CAGR, %



⁴² Based on McKinsey analysis of deal flow data from Capital IQ, Dealogic, and Levin Associates.

⁴³ Ibid.

⁴⁴ Ibid.

⁴⁵ Based on McKinsey analysis of data from Bloomberg, MSCI North America, and Preqin.

⁴⁶ Based on McKinsey analysis of the current share of assets under management in healthcare for institutional investors.

In this investment environment, incumbents such as large health systems, ancillary providers, and insurers should consider strategic partnerships with emerging innovators, including technology and services companies backed by venture capital and private equity. The goal would be to build an ecosystem of alliances to support the future of care delivery.⁴⁷

Finally, private investors should aspire to improve the quality of care and health outcomes as well as to institute more effective management across vulnerable populations, ensuring long-term sustainability and growth. This will require guardrails and performance management systems to monitor the impact of investments on healthcare improvements.

Both fragmented and integrated

To support greater patient-centricity and on-demand accessibility, care delivery in the United States is evolving toward greater integration of care around the patient. We can see this in the emergence of “one stop shop” innovators in care management and care coordination. These players partner with payers, providers, and, in some cases, employers to ease consumers’ navigation of complex care journeys, such as prenatal care or kidney disease management. Consolidation is occurring as well. For example, payer incumbents are investing in data-driven care delivery start-ups. Hospital

systems are acquiring provider groups and pursuing partnerships or joint ventures with providers of post-acute and ambulatory care to support value-based strategies.

But the development of more integrated models will take time. Paradoxically, the ongoing shift from hospital-based, specialized care to more value-based, consumer-centric models will create even more access points in the care journey (for example, primary care, diagnostics, prevention, and wellness). As more players enter the scene, fragmentation will persist.

In time, we may see a new type of “integrated yet fragmented” ecosystem. In this model, atomized sites of care would work in concert with one another, while technology-enabled platforms facilitate easy transfer and sharing of data,⁴⁸ clinical care is harmonized, and patients seamlessly transition from one part of their care journey to the next.

There are major changes ahead in the delivery of care in the United States. Participants in the healthcare system must reflect on how the ten shifts described above will influence their strategies over the next decade. One thing is certain: there’s no stopping innovation in the delivery of care. The open question is how players can support that innovation and take advantage of it to the benefit of consumers and society in general.

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⁴⁷ Zachary Greenberg, Basel Kayyali, Rob Levin, and Shubham Singhal, “The next wave of healthcare innovation: The evolution of ecosystems,” McKinsey, June 23, 2020.

⁴⁸ Data sharing would be in compliance with HIPAA rules, patient privacy, and data security considerations.