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The health of nations: Stronger health, stronger economies

Poor health imposes a heavy human and economic toll. Scaling proven interventions could add nine healthy years to life and deliver $12.5 trillion in global economic gains by 2050.

February 2026

Contents

Foreword

Improving health is one of the most powerful and measurable ways to strengthen societies. Every country, regardless of income level, faces mounting pressures from aging populations, increasing cases of chronic disease, and widening inequities in access to care. As this report from the McKinsey Health Institute shows, the trajectory is not preordained. The choices leaders make today will determine whether billions of people live longer, healthier lives or spend more years in poor health while economies struggle under the weight of preventable disease. It is encouraging to see data from the Global Burden of Disease (GBD) Study used here to clarify both the scale of the challenge and the substantial opportunities for improvement. That's because, for more than three decades, the GBD Study, centered at the Institute for Health Metrics and Evaluation, based at the University of Washington, has worked to build a comprehensive evidence base on population health. The GBD was designed to help decision-makers understand where people are losing years of life and years of good health, what is driving these losses, and which interventions have demonstrated impact. The modeling presented in this report reflects how these data can support practical analysis of what is achievable when proven, cost-effective interventions are expanded.

The findings point to an important conclusion. If stakeholders scale interventions already known to work, the world could reduce the disease burden substantially by 2050, prevent millions of premature deaths, and add nearly a decade of healthy life for the average person. These insights emerge from using consistent and comparable data to examine risk factors, interventions, and demographic trends together. They help identify where action is likely to yield the greatest gains and support more strategic allocation of resources.

Real progress depends not only on understanding these opportunities but on acting on them. Evidence allows leaders to see where need is most acute, where interventions have the strongest track record, and how investments can generate both health and economic value. Data of this kind provide a foundation for setting priorities and evaluating the effects of those choices over time.

The work in this report demonstrates how measurement can inform a clearer path forward. By applying the evidence to quantify what improved health could mean for societies and economies, the report contributes important analysis to the global discussion on how to extend healthy life and strengthen resilience. Efforts like this help support more informed decision-making, and they add momentum to the growing recognition that health is central to long-term development.

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Preface

Health is deeply personal and yet profoundly economic. It shapes how long people live, how well they live, and how societies grow and prosper. Over the past century, advances in public health and medicine have added decades to global life expectancy, improving well-being while fueling economic progress. Yet today, as populations age and chronic diseases increase, the world faces a paradox: People are living longer but spending more of those years in poor health. The human costs are substantial, and the economic consequences are increasingly evident.

At the same time, health is too often viewed primarily as a cost to be managed rather than an investment to be made. Short-term fiscal pressures, rising healthcare expenditures, and competing public priorities have narrowed the policy debate, crowding out a longer-term view of how better health can strengthen societies and economies. Grounded in rigorous analysis and research, this report makes the case for reframing health as an investment.

In this report, we examine what it would take to meaningfully improve health by scaling access to proven, cost-effective interventions. Drawing on new analysis across more than 200 countries, we estimate the potential benefits for individuals, societies, and the global economy through 2050. The findings point to a powerful opportunity: Better health could add years of healthy life for billions of people while generating trillions of dollars in economic value.

This research is the product of a yearlong effort by the McKinsey Health Institute (MHI), in collaboration with colleagues across McKinsey and external experts and partners. It builds on decades of McKinsey research on productivity, demographics, and economic growth, as well as deep expertise in healthcare systems, prevention, data and analytics, and public health. Our aim is to contribute evidence and perspective to a critical global conversation, not to provide medical, policy, or investment advice.

The research was led by Brad Herbig, a senior fellow and director of health data and analytics at MHI, based in the Washington, DC, office; Alex Beauvais, a global director of MHI and a partner in McKinsey's London office; Pooja Kumar, a global leader of MHI and a senior partner in the Philadelphia office; and Matt Wilson, an MHI-affiliated leader and a senior partner in the New York office. The project team was led by Pooja Tatwawadi and Grail Dorling.

We are very grateful to the Institute of Health Metrics and Evaluation for ongoing support and insight. In particular, we would like to thank Charles Jonscher, head of the client services unit; William Heisel, director of global services; Stephen Lim, professor of health metric sciences; and Christopher J. L. Murray, director. We would also like to thank several individuals who generously contributed their time, expertise, and advice, including David M. Cutler, Otto Eckstein Professor of Applied Economics, Harvard University; Debra A. Pinals, clinical adjunct professor at University of Michigan; Henry Chung, professor of Psychiatry at the Albert Einstein College of Medicine; Karen Hacker, adjunct professor of Health Policy and Management at Emory University; Kristin-Anne Rutter, executive director at Cambridge University Health Partners; and Orin S. Levine, president and CEO at the Washington Research Foundation.

We also wish to thank the many past and present colleagues at MHI and McKinsey for their valuable help and expertise, including Alan Salih, Ananya Pramanik, Anas El Turabi, Anu Madgavkar, Carl Okunubi, Cary Mei, Cedric Tehranian, Christina Gupfinger, Claudia von Hammerstein, Connor Rochford, Danya Sbano, Emma Summerton, Eric Koskins, Erica Coe, Helena Cubas, Ian Lyons, Irina Zolotnitskaya, Javier Valenzuela, Jeffrey Algazy, Joachim Bleys, Kana Enomoto, Katherine Linzer, Kelsia Adil, Lars Hartenstein, Lucy Pérez, Magdalena Rojek, Maitham Albaharna, Marie-Renée B-Lajoie, Marino MB, Mark Canal, Mark Zaki, Matt Craven, Nicolas Abi-Chacra, Nur Amalina Ismail, Pedro Sousa Silva, Roxy Merkand, Sandya Ganesh, Sara Ristola, Sarah Pickard, Ulrich Bork, Unnati Mehta, and Vamsi Reddy. This article was edited by Elizabeth Newman, an executive editor in the Chicago office.

As with all MHI research, this work is independent, reflects our own views, and has not been commissioned by any business, government, or other institution. We hope it helps elevate the discussion on health from a necessary expense to a powerful catalyst for human and economic progress.

Executive summary

Over the past century, advances in vaccination, sanitation, and primary care have added decades to global life expectancy. Yet the world is living longer, not healthier. By 2050, the average person is projected to spend 11.4 years in poor health, up from 10.2 years in 2025 and 8.7 years in 2000. The rapid rise of noncommunicable diseases means that more people are managing chronic illness for longer, creating profound social and economic consequences.

This burden is intensifying as populations age. By 2050, one in six people worldwide will be over 65, compared with one in ten today. Longer lives spent in poor health are not only straining health systems but also weighing on economic productivity and labor supply. At the same time, rising debt servicing and defense spending are squeezing public budgets, crowding out investment in prevention and care.

Yet this trajectory is not inevitable. Expanding access to proven health interventions offers a clear path to "bend the curve" of disease. McKinsey Health Institute analysis of nearly 300 cost-effective interventions across more than 200 countries shows that scaling them to aspirational but achievable levels by 2050 could have a substantial impact.

— *Society could reduce the global disease burden by 35 percent,* saving 33 million lives and preventing more than 460 million years of poor health—equivalent to adding nearly a decade of healthy life for the average person. Roughly two-thirds of this gain would come from preventive measures, many of which are delivered outside healthcare systems.

— *Better health could add $12.5 trillion to the global economy annually by 2050,* a 7 percent lift in global GDP driven largely by higher labor-force participation and reduced morbidity among working-age adults.

— *Every $1 invested in health could yield $4 in economic value,* with some interventions, such as tobacco control and antihypertensive treatment, offering even higher returns.

Achieving this future requires three key actions:

— *Aligning incentives to reward long-term investment in prevention:* Prevention can deliver some of the highest returns in health, yet accounts for less than 2 percent of health spending in most countries. Outcome-based financing and evidence-driven fiscal and regulatory tools can help make prevention investable at scale.

— *Unleashing multisectoral action to drive progress in health and beyond:* Health is everyone's business. Coordinating action and investment across sectors and mobilizing private finance and know-how can transform health from a cost to a catalyst. Better health can be self-reinforcing with other societal priorities such as education, physical infrastructure, and workforce productivity.

— *Boosting health spending efficiency to maximize outcomes:* Smarter, data-driven systems can achieve more health with existing resources. Reorienting service delivery toward primary and community care settings, modernizing procurement approaches, integrating data platforms, and enabling individuals to actively manage their health can help increase the health returns to health spending.

The urgency to act is clear, and proven interventions are within reach. The real question is not whether the world can afford to invest in health, but whether it can afford not to.

Introduction

Public health advances over the past century have driven remarkable gains in human longevity. Global life expectancy has risen sharply due to breakthroughs in communicable disease control, maternal and child health, and widespread adoption of interventions such as vaccination, antibiotics, improved sanitation, and primary care. By 2050, an individual is expected to live to 78 years, on average, an 11-year increase over the prior 50 years. Yet, longer lifespans do not necessarily translate into healthier lives. Although people are living longer, they are also spending more of those years in poor health. The average time lived with illness has increased from about 8.7 years in 2000 to 10.2 years in 2025 and is projected to reach 11.4 years by 2050 (Exhibit 1). The demographic shift toward older populations, combined with a rising prevalence of noncommunicable diseases (NCDs) such as cardiovascular disease, diabetes, cancer, and mental health conditions, means more people will be managing chronic illnesses for longer.

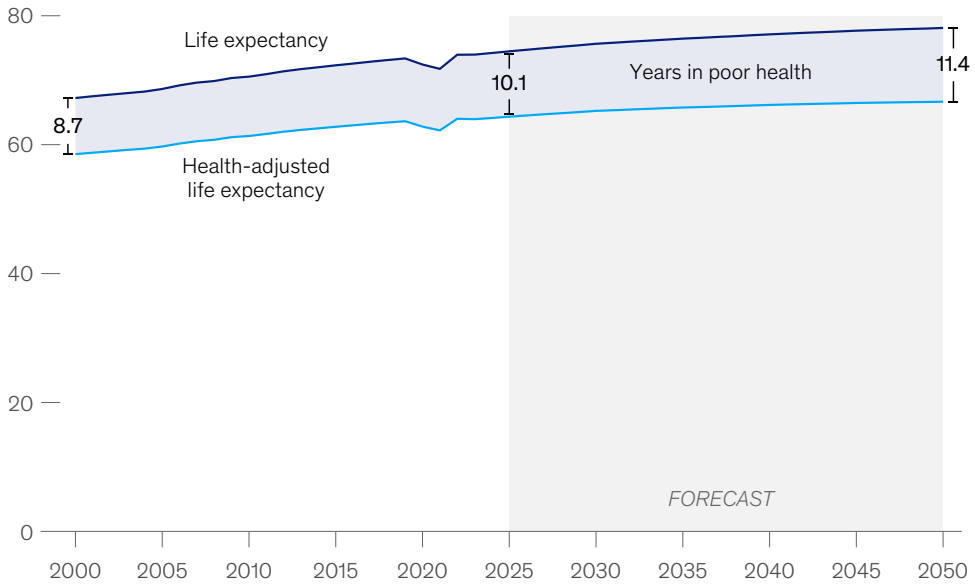
The combination of aging populations and increasing chronic disease prevalence is straining economies and health systems worldwide. As highlighted in the 2025 McKinsey Global Institute report, "Dependency and depopulation? Confronting the consequences of a new demographic reality," the demographic shift toward more older individuals and fewer working-age people is poised to slow the growth of total hours worked, ultimately dampening GDP per capita growth if left unaddressed.[1]

[1] "Dependency and depopulation? Confronting the consequences of a new demographic reality," McKinsey Global Institute, January 15, 2025.

Exhibit 1

People are living longer, but they are also living longer in poor health.

Global health span and lifespan gap, years



Source: Global Burden of Disease Database, Institute for Health Metrics and Evaluation, 2021 (used with permission, all rights reserved)

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At the same time, fiscal pressures are deepening the challenge. Healthcare budgets in many countries are being squeezed by competing demands, including rising defense expenditures, higher debt-servicing costs, and declining development aid. Debt servicing now exceeds healthcare spending in almost 62 countries, limiting their capacity to invest in health systems and preventive care.[2] In 2024, official developmental assistance fell by 9 percent,[3] and preliminary estimates suggest that 2025 levels were the lowest in more than 15 years.[4] While some middle-income countries may offset these gaps with domestic resources, many low-income nations, particularly in sub-Saharan Africa, lack the fiscal space to do so. Hard-won gains in communicable disease control are therefore at risk of reversal.

This trajectory is not inevitable. By scaling timely access to proven cost-effective health interventions, societies can "bend the curve" of the burden of disease, averting 35 percent of the total burden in 2050, avoiding 33 million premature deaths and more than 461 million years of poor health (see sidebar "Definitions"). Nearly two-thirds of this impact would come from prevention, yet countries allocate, on average, less than 2 percent of health spending to preventive care. This translates into roughly 18 additional healthy days per person each year. Regardless of country,

[2] "Lost decade looms for debt-ridden developing countries: UNCTAD," UN News, April 12, 2023.
[3] "Cuts in official development assistance: OECD projections for 2025 and the near term,"*OECD Policy Briefs*, 2025, Number 26.
[4] *Financing global health 2025: Cuts in aid and future outlook*, Institute for Health Metrics and Evaluation, July 31, 2025.

Definitions

Disability-adjusted life years (DALYs): DALYs reflect the total years of healthy life lost due to health conditions. This summary measure of health burden was developed as part of the Global Burden of Disease study to compare total health loss attributed to disparate health conditions by combining condition-related suffering and premature death. Ranking health conditions by DALYs allows decision-makers to identify the health problems that contribute to the greatest loss of healthy life in a given population, whether by people dying when they are very young, by shortening lives by a few years, or by causing daily, long-term suffering. Mathematically, condition-specific DALYs reflect the sum of years lived with disability and years of life lost due to premature mortality.

Years lived with disability (YLDs): YLDs quantify the number of full years of healthy life that are lost in a given population while living with diseases and injuries that degrade health in a given year. They are calculated by multiplying the severity of each condition by the prevalence of each condition. YLDs take into account all disabilities that occur in a given calendar year, including lower-visibility ones that result in daily pain, lost work time, or an inability for someone to thrive as they otherwise might. Acute health problems and chronic conditions could result in the same number of YLDs in a given calendar year, depending on condition severity and the number of people afflicted with each condition.

Years of life lost (YLLs): YLLs quantify the years of life lost in a year due to premature deaths. YLLs are calculated by multiplying the number of deaths occurring in a population at a given age in a given year by the global standard remaining life expectancy at the age at which death occurs. This global standard reflects the highest life expectancy observed today, representing a hypothetical best-case global health scenario. YLLs for a given year take into account all future years of life that would have been expected for individuals who die in that year.

Health-adjusted life expectancy (HALE): HALE is the average number of years that a person can expect to live in good health, if the rates of all-cause mortality and all-cause disability in a specified year of interest would remain constant into the future.[1]

[1] Global Burden of Disease Study 2021 (GBD 2021), Institute for Health Metrics and Evaluation, 2024 (used with permission, all rights reserved).

those additional days offers benefits beyond productive work: it's additional time with friends and family, to pursue accomplishments, build a community, or simply to live without cognitive or physical impairment.

The economic case for investing in health is equally compelling. Improving access to proven, cost-effective interventions could boost global GDP by an additional $12.5 trillion annually by 2050, equivalent to about 7 percent of global output, yielding a global economic return on investment of about four to one.

Why isn't this happening already? Persistent barriers such as short-termism, siloed systems, and institutional inertia make it more challenging to prioritize the actions and investments needed for health. However, three actions can help overcome these barriers to make this healthier future a reality. Funders can align incentives to reward long-term investment in prevention. Stakeholders beyond healthcare, both in the public and private sectors, can play a role in unleashing multisectoral action to propel progress in health and beyond. And health systems can generate more health per dollar by pairing investment with better cost management. By doing this, health could become a powerful driver of both societal and economic progress.

1 The current path: How demographic and disease burden shifts are shaping global health

Over the past 25 years, the global demographic landscape has experienced profound changes, characterized by aging populations, rapid urbanization, and evolving lifestyle patterns. These demographic shifts have been closely linked to a transition in the global disease burden, with a decline in infectious diseases such as HIV/AIDS, tuberculosis, and malaria, and a concurrent rise in NCDs such as cardiovascular diseases, diabetes, mental disorders, and cancers. This section explores the key demographic and disease burden transitions, the underlying drivers of these changes, and their implications for health systems, economies, and societies worldwide.

Demographic shifts, 2000–50

In 2000, much of the world stood in earlier stages of the demographic transition, marked by higher fertility rates, younger populations, and lower life expectancy compared with today (Exhibit 2a).

Exhibit 2a

Demographic transitions are unfolding across countries.

Population breakdown by sex and age group, by country economic archetype

Note: Pyramids are drawn to scale within each economic archetype but not between archetypes.
Source: Global Burden of Disease Database, Institute for Health Metrics and Evaluation, 2021 (used with permission, all rights reserved)

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Over the past 25 years, the world has undergone profound demographic shifts (Exhibit 2b). Populations are aging globally, particularly in high- and upper-middle-income countries. Life expectancy has risen steadily worldwide, while fertility rates are declining, having fallen to 2.2 by 2024.[5] In high- and upper-middle-income countries, these trends have led to slower population growth, a shrinking younger generation, and an increasing share of people over age 65, all contributing to a decreasing support ratio, defined as the number of working-age individuals (typically aged 15–64) per person aged 65 and older. Younger people could face increasing pressure to generate incomes for their own families while caring longer for their elders. For countries, these demographic shifts are placing growing pressure on health systems, labor markets, and social protection programs.

In contrast, low- and lower-middle-income countries tend to have younger populations. Many are entering a period where large cohorts of youth are transitioning into the workforce, creating a time-bound opportunity for a "demographic dividend" to boost economic growth, but only if health, education, and employment systems are strong enough to support and fully engage these populations.

Exhibit 2b

Demographic transitions are unfolding across countries.

Population breakdown by sex and age group, by country economic archetype 2025

Note: Pyramids are drawn to scale within each economic archetype but not between archetypes.
Source: Global Burden of Disease Database, Institute for Health Metrics and Evaluation, 2021 (used with permission, all rights reserved)

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Over the next 25 years, these demographic shifts are projected to continue and become more pronounced (Exhibit 2c). A steadily aging global population is expected to lead to a transformation in the composition and distribution of the working-age population. By 2050, the workforce in high-income and upper-middle-

[5] *World fertility 2024*, United Nations, 2025.

income countries is projected to shrink by 5 to 7 percent, while it is expected to grow by 9 to 12 percent in low- and lower-middle-income countries. This shift, combined with continued population growth in low-income (LICs) and low-and-middle-income countries (LMICs), will reshape global health needs. As a result, disease burden will evolve differently across income archetypes, with aging and chronic conditions dominating in wealthier countries, while many LMICs contend with a dual burden of infectious diseases and rising NCDs.

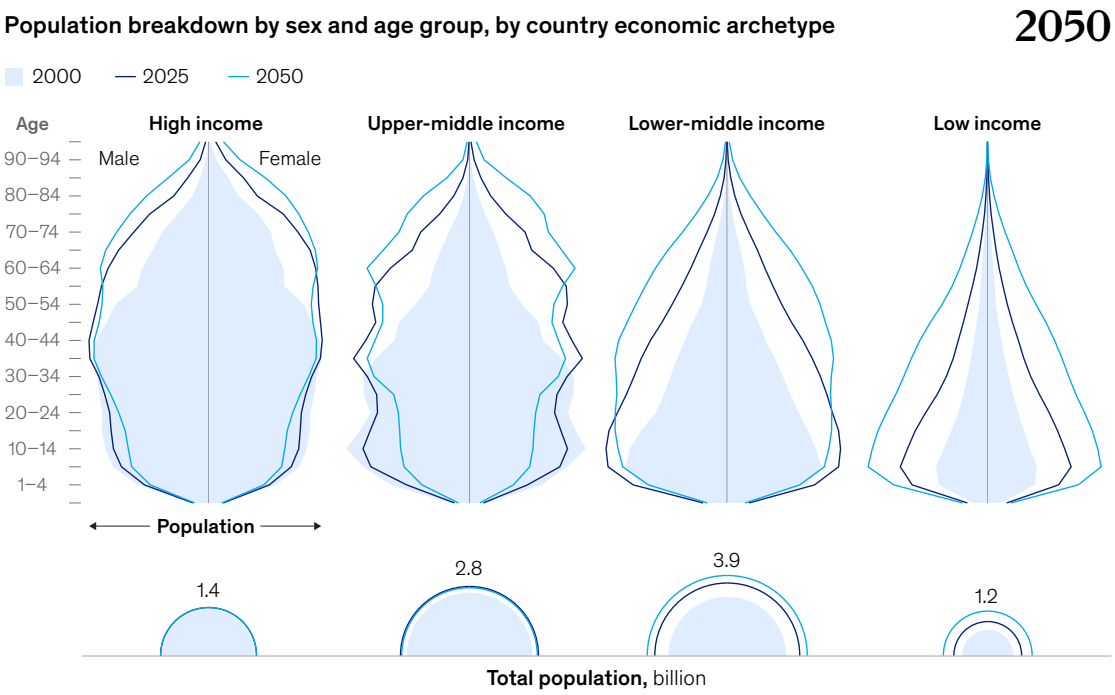
In addition to national demographic shifts, population distribution within countries is also changing. Rapid urbanization and increased mobility have transformed where and how people live. More than 55 percent of the global population resides in urban areas, with that share projected to rise to 68 percent by 2050.[6] This urban growth is altering patterns of disease exposure, placing increasing strain on infrastructure and services, and reshaping both the public health landscape and broader economic systems. This shift also presents an opportunity to design healthy cities that can provide rapid access to high-quality services with economies of scale and create built environments that promote and support healthy behaviors and choices. At the same time, many rural areas face contrasting challenges—such as population decline, limited access to healthcare and digital infrastructure, and shortages of skilled health workers—which risk deepening health inequities between urban and rural populations.

[6] *Sustainable Development Goals*, "68% of the world population projected to live in urban areas by 2050, says UN," United Nations, May 16, 2018.

Exhibit 2c

Demographic transitions are unfolding across countries.

Population breakdown by sex and age group, by country economic archetype



Note: Pyramids are drawn to scale within each economic archetype but not between archetypes.
Source: Global Burden of Disease Database, Institute for Health Metrics and Evaluation, 2021 (used with permission, all rights reserved)

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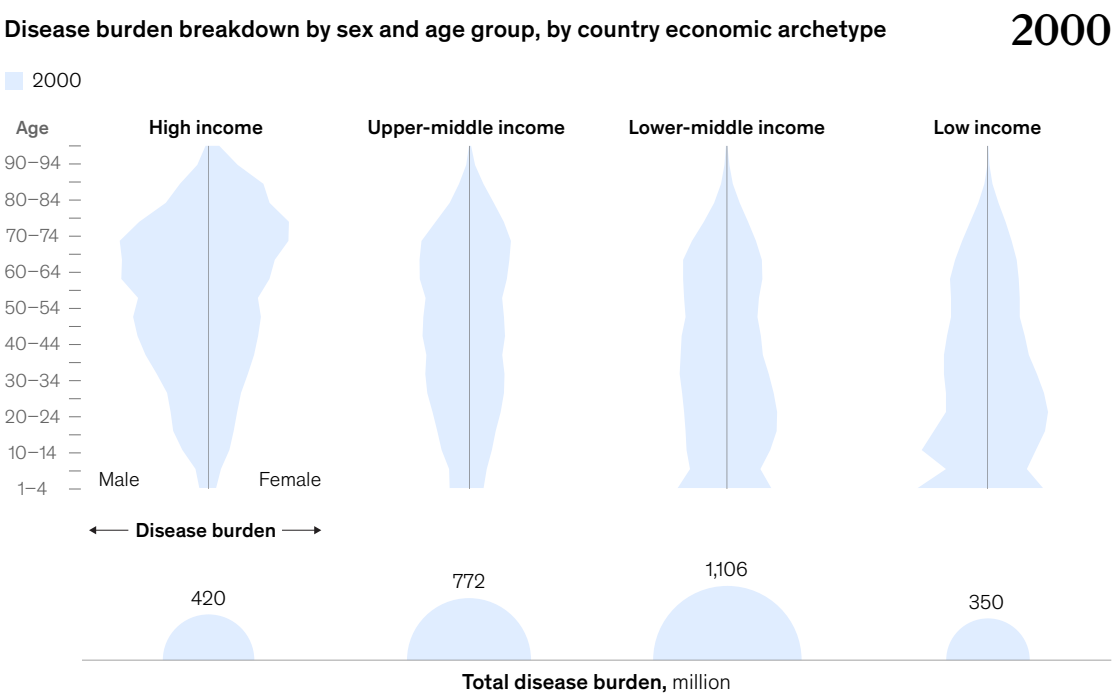
Disease burden shifts, 2000–50

Twenty-five years ago, the global disease burden was more concentrated in younger age groups, particularly in middle- and low-income countries (Exhibit 3a).

Exhibit 3a

Distribution of disease burden is shifting as populations age.



Note: Pyramids are drawn to scale within each economic archetype but not between archetypes. The less than 1-year-old cohort is not shown. In low- and lower-income countries, a substantial share of the disease burden is attributable to high infant mortality.
Source: Global Burden of Disease Database, Institute for Health Metrics and Evaluation, 2021 (used with permission, all rights reserved)

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Since 2000, the global disease burden per capita has declined by 24 percent, driven largely by progress in combating infectious diseases and improving maternal and child health. Key initiatives include vaccination programs,[7] the scale-up of HIV prevention tools such as PrEP,[8] and expanded access to viral hepatitis treatment.[9] These and other efforts have helped prevent millions of deaths and improved health outcomes, particularly in low-middle- and low-income countries, where the disease burden per capita declined by 36 percent and 54 percent, respectively.

[7] Minal K. Patel et al., "Progress toward regional measles elimination — worldwide, 2000–2015,"*Morbidity and Mortality Weekly Report*, 2016, Volume 65, Number 44.
[8] Eamon O. Murchu et al., "Oral pre-exposure prophylaxis (PrEP) to prevent HIV: A systematic review and meta-analysis of clinical effectiveness, safety, adherence and risk compensation in all populations," *BMJ Open*, 2022, Volume 36, Number 5.
[9] Mohammad T. Yousafzai et al., "Global cascade of care for chronic hepatitis C virus infection: A systematic review and meta-analysis," *Journal of Viral Hepatitis*, 2021, Volume 28, Number 10.

At present, the global disease burden is continuing to shift from communicable diseases to NCDs, underscoring an ongoing epidemiological transition. In 2025, NCDs are expected to account for 76 percent of all global deaths and 82 percent of total years lived in poor health, as opposed to 63 percent and 77 percent, respectively, in 2000. This shift is driven by both public health gains in controlling infectious diseases and broader sociodemographic changes. Changes in lifestyle and behavior, such as rapid urbanization and evolving dietary and physical activity patterns, have fueled the rise of NCDs such as diabetes, cardiovascular disease, and cancer.[10] Today's challenge lies in sustaining infectious disease control while expanding capacity to prevent and manage chronic conditions.

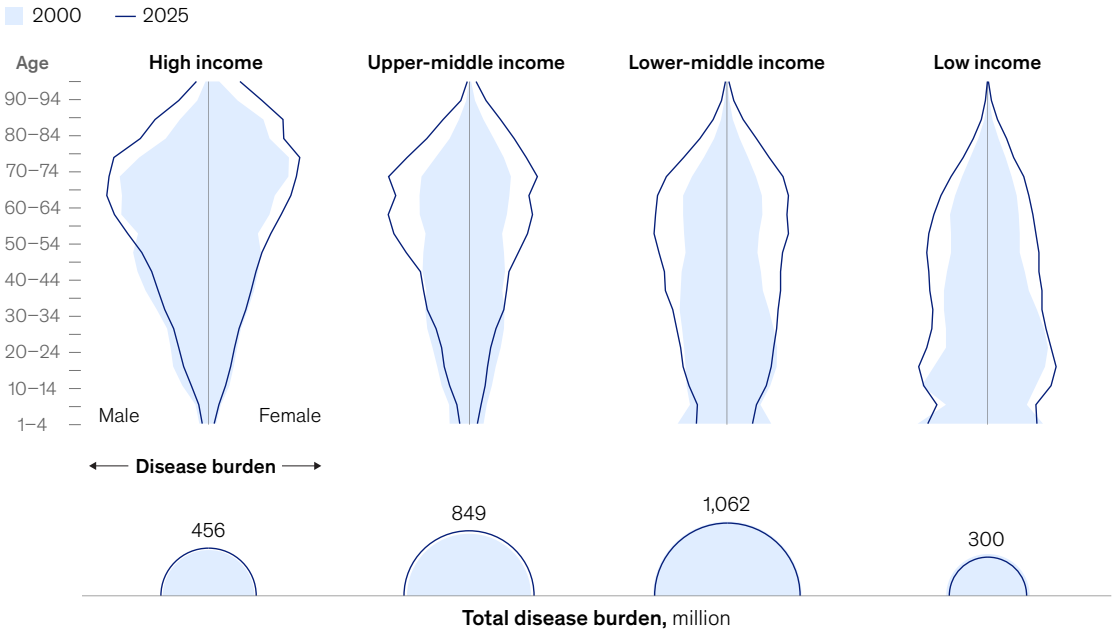
Moreover, significant sex differences in disease burden also persist. Women live about five years longer than men on average,[11] but spend 25 percent more years in poor health than men do.[12] Men bear a higher burden from diseases driven by years of life lost, such as cardiovascular diseases and cancers, while women face greater burdens from diseases driven by years lived with disability, such as musculoskeletal and mental disorders (see sidebar "Closing sex-based health gaps"). These differences in burden patterns highlight the importance of considering sex-based differences in addressing this burden (Exhibit 3b).

[10] Global Burden of Disease Database, Institute for Health Metrics and Evaluation, 2021 (used with permission, all rights reserved).
[11] Global Burden of Disease Database, Institute for Health Metrics and Evaluation, 2021 (used with permission, all rights reserved).
[12] Kweilin Ellingrud, Lucy Pérez, Anouk Petersen, and Valentina Sartori, *Closing the women's health gap: A $1 trillion opportunity to improve lives and economies*, McKinsey Health Institute, January 17, 2024.

Exhibit 3b

Distribution of disease burden is shifting as populations age.

Disease burden breakdown by sex and age group, by country economic archetype 2025



Note: Pyramids are drawn to scale within each economic archetype but not between archetypes. The less than 1-year-old cohort is not shown. In low- and lower-income countries, a substantial share of the disease burden is attributable to high infant mortality.
Source: Global Burden of Disease Database, Institute for Health Metrics and Evaluation, 2021 (used with permission, all rights reserved)

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Closing sex-based health gaps

Sex-based differences exist both in the burden across different diseases and in the access to effective health interventions to address them.

Men and women experience markedly different patterns of disease burden. Men tend to face higher burdens from diseases that mostly impact years of life lost (YLLs), including cardiovascular disease, cancers, and substance use disorders.[1] Notably, even in disease categories often associated with women, such as maternal and neonatal disorders, male infants experience a greater burden of neonatal conditions due to greater biological vulnerability, including less-developed lungs and immune systems.[2]

Women, by contrast, experience a greater share of diseases that mostly impact years lived with disability (YLDs), including musculoskeletal and mental health conditions.[3] They are also disproportionately affected by neurological disorders such as Alzheimer's disease, in which heightened risk is linked to sex-specific factors, including genetic differences, hormonal changes, responses to aging, and psychosocial influences.[4]

Disease patterns may partially derive from the biological and social differences that translate into unequal access to effective health interventions, creating persistent gaps in prevention, diagnosis, and treatment. For example, despite facing higher mortality from preventable and treatable conditions, men often underutilize health services and engage less in preventive care.[5] Cultural norms around masculinity,[6] lower health-seeking behavior, and higher exposure to risk factors, such as tobacco use, alcohol consumption,[7] and occupational hazards,[8] contribute to delayed diagnosis and poorer outcomes. Men are also less likely to participate in routine screening programs, amplifying the impact of diseases such as cardiovascular illness, cancers, and substance use disorders.[9] Addressing these behavioral and systemic barriers is critical to reducing men's overall disease burden.

For women, gaps in the effectiveness and adoption of health interventions persist, even in disease areas where aggregate burden is lower than for men. Many programs are built on male-dominant data and research models, resulting in poorer recognition, diagnosis, and treatment for women.[10] While women bear a greater share of diseases associated with YLDs, research and investment have also fallen short in high-mortality conditions, where sex-specific differences in presentation and response to treatment matter. In cardiovascular disease, for example, under-recognition in women can delay or limit the use of effective therapies such as statins, contributing to poorer outcomes.[11] Nonfatal but debilitating conditions such as endometriosis and menopause are also understudied and undertreated.[12] Further barriers, including limited access to care,[13] high costs,[14] time constraints linked to unpaid caregiving,[15] and insufficiently tailored services,[16] compound these challenges. Broader McKinsey Health Institute analysis shows that closing the women's health gap in intervention efficacy, adoption, and data could add $1 trillion annually to the global economy by 2040, and nearly seven healthy days per woman per year.[17]

[1] Global Burden of Disease Study 2021 (GBD 2021), Institute for Health Metrics and Evaluation, 2024 (used with permission, all rights reserved).
[2] Krithika Lingappan et al., "The need to address sex as a biological variable in neonatal clinical studies," *Journal of Pediatrics*, 2022, Volume 255.
[3] Global Burden of Disease Study 2021 (GBD 2021), Institute for Health Metrics and Evaluation, 2024 (used with permission, all rights reserved).
[4] Mary A. O'Neal, "Women and the risk of Alzheimer's disease," *Frontiers in Global Women's Health*, 2024, Volume 4; Laura Castro-Aldrete et al., "Women's brain health and brain capital," *Nature Mental Health*, 2025, Volume 3.
[5] Haffis Arsat et al., "Men health seeking behaviour: A literature review," *Environment-Behaviour Proceedings Journal*, 2022, Volume 7, Number 20.
[6] Cody Ragonese and Gary Barker, "Understanding masculinities to improve men's health,"*Lancet*, 2019, Volume 394, Number 10194.
[7] James P. Byrnes, David C. Miller, and William D. Schafer, "Gender differences in risk taking: A meta-analysis," *Psychological Bulletin*,1999, Volume 3.
[8] Mary Stergiou-Kita et al., "Danger zone: Men, masculinity and occupational health and safety in high risk occupations," *Safety Science*, 2015, Volume 80.
[9] Chin Hai Teo et al., "Improving health screening uptake in men: A systematic review and meta-analysis," *American Journal of Preventive Medicine*, 2018, Volume 54, Number 1.
[10] Judith G. Regensteiner et al., "Barriers and solutions in women's health research and clinical care: A call to action," *Lancet Regional Health – Americas*, 2025, Volume 44, Number 101037.
[11] Lucy Pérez and Megan Greenfield, *The state of US women's heart health: A path to improved health and financial outcomes*, McKinsey Health Institute, June 25, 2024.
[12] Kweilin Ellingrud, Lucy Pérez, Anouk Petersen, and Valentina Sartori, *Closing the women's health gap: A $1 trillion opportunity to improve lives and economies*, McKinsey Health Institute, January 17, 2024.
[13] Allison Gilchrist et al., "Factors affecting women's access to primary care in the United States since the Affordable Care Act: A mixed-methods systematic review," *PLoS One*, 2024, Volume 19, Number 12.
[14] Giuliana Grossi, "US women face worst health access, outcomes among high-income nations," *American Journal of Managed Care*, August 15, 2024.
[15] Nathan M. Stall et al., "Unpaid family caregiving—the next frontier of gender equity in a postpandemic future," *JAMA Health Forum*, 2023, Volume 4, Number 6.
[16] Judith G. Regensteiner et al., "Barriers and solutions in women's health research and clinical care: A call to action," *Lancet Regional Health – Americas*, 2025, Volume 44.
[17] Kweilin Ellingrud, Lucy Pérez, Anouk Petersen, and Valentina Sartori, *Closing the women's health gap: A $1 trillion opportunity to improve lives and economies*, McKinsey Health Institute, January 17, 2024.

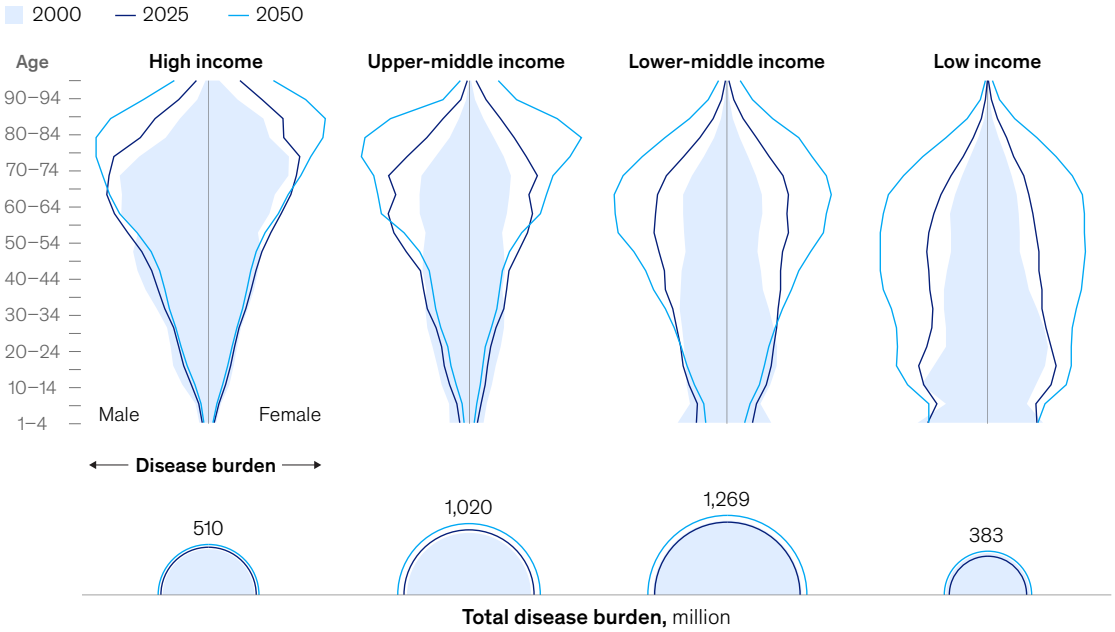
According to disease burden projections by the Institute for Health Metrics and Evaluation (IHME), these trends are expected to persist in the future, with longer lifespans and the predominance of chronic conditions, continuing to shift most of the burden toward older age groups (Exhibit 3c).

This growing burden places increasing strain on health systems, particularly those not historically equipped to manage chronic conditions at scale, and underscores the need for health systems to move beyond a focus only on mortality reduction and instead invest in strategies that promote healthy aging, functional ability, and support for those living with chronic conditions. As demand for long-term and chronic care rises, the role of the care economy becomes increasingly critical, both in providing direct support to older populations and in enabling labor force participation among younger people through accessible and reliable caregiving.

Exhibit 3c

Distribution of disease burden is shifting as populations age.

Disease burden breakdown by sex and age group, by country economic archetype **2050**



Note: Pyramids are drawn to scale within each economic archetype but not between archetypes. The less than 1-year-old cohort is not shown. In low- and lower-income countries, a substantial share of the disease burden is attributable to high infant mortality.
Source: Global Burden of Disease Database, Institute for Health Metrics and Evaluation, 2021 (used with permission, all rights reserved)

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What the growing disease burden means for global health

The world's population is projected to grow from 8.1 billion in 2025 to 9.3 billion by 2050, and with more people comes a higher absolute burden of disease. But population growth is only part of the story. The world is also aging rapidly: The number of people over 65, the group that already accounts for the majority of healthcare spending, will nearly double from 862.0 million to 1.6 billion.

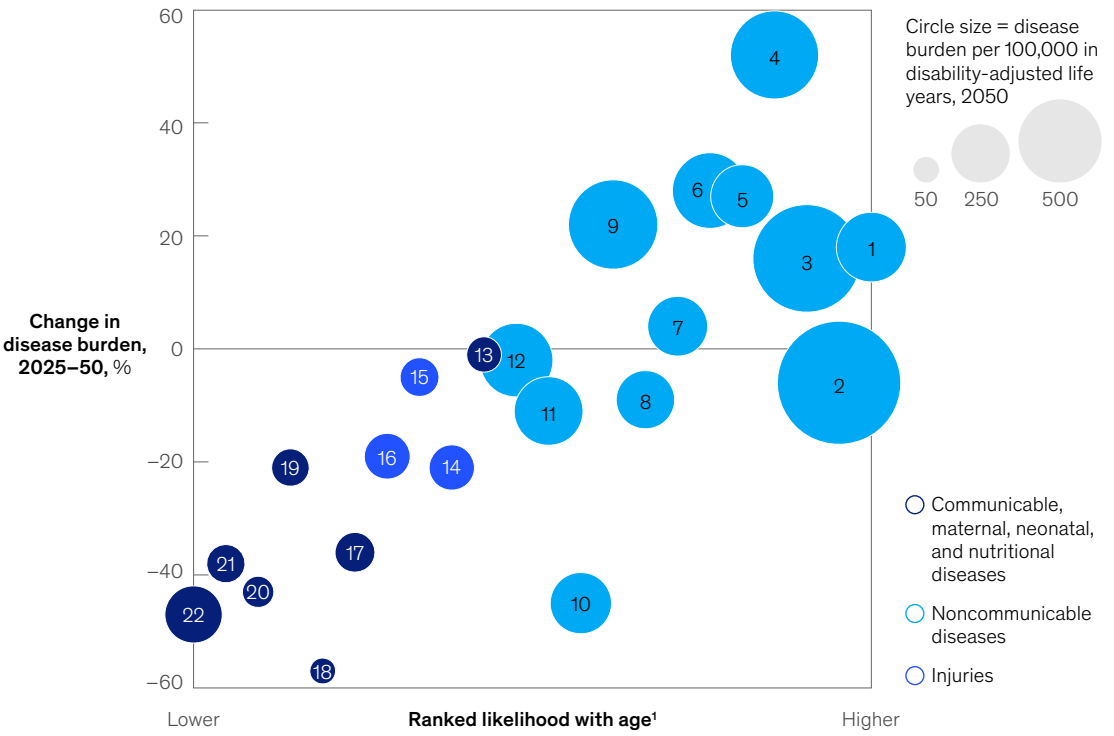
This demographic shift will sharply increase the prevalence of NCDs such as cardiovascular disease, cancer, and neurological disorders (Exhibit 4). Between 2025 and 2050, the total global disease burden is expected

to rise by 19 percent, driven largely by years lived in poor health. While population growth will contribute to the overall increase in disease burden, a per capita perspective reveals a key turning point: global disease burden per capita declined by approximately 24 percent over the past 25 years but is projected to increase by about 4 percent over the next 25 years, marking a shift in recent health gain trends.

Exhibit 4

As the population ages, the incidence of age- and lifestyle-related diseases is expected to increase.

Change in disease burden, 2025–50 vs likelihood with age, global



22	Maternal and neonatal disorders	**16**	Self-harm and interpersonal violence	**9**	Musculoskeletal disorders
21	Neglected tropical diseases and malaria	**15**	Skin and subcutaneous diseases	**8**	Unintentional injuries
20	Other infectious diseases	**14**	Transport injuries	**7**	Digestive diseases
19	Nutritional deficiencies	**13**	Substance use disorders	**6**	Neurological disorders
18	HIV/AIDS and sexually transmitted infections	**12**	Mental disorders	**5**	Sense organ diseases
17	Enteric infections	**11**	Other noncommunicable diseases	**4**	Diabetes and kidney diseases
		10	Respiratory infections and tuberculosis	**3**	Cancers
				2	Cardiovascular diseases
				1	Chronic respiratory diseases

[1]Disease likelihood was estimated by examining global age-specific burden and ranking conditions by the strength of their association with each age group.
Source: Global Burden of Disease Database, Institute for Health Metrics and Evaluation, 2021 (used with permission, all rights reserved)

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To put this into perspective, by 2050, the world will face an additional 500 million DALYs, the equivalent of adding 1.5 billion people's worth of healthcare demand, while the actual population rises by only 1.2 billion. The difference, 334 million people's worth of demand, is like adding the entire healthcare demand of another United States.

Unsurprisingly, this rising burden will translate into soaring costs. Global healthcare spending is projected to climb from $11.2 trillion today to $20.5 trillion in 2050, rising from 10 percent to 11 percent of global GDP.[13] That additional $10 trillion is almost double the size of today's entire global tech industry.[14]

At the same time, the economic toll of poor health will deepen. Lost productivity and reduced labor force participation are expected to increase from 17 percent to 23 percent of global GDP. This double bind—higher costs and a shrinking workforce to pay them—poses a major threat to economic growth.

Against this backdrop, investing in health is not just a moral imperativeaction. It is an economic necessity.

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[13] *Financing Global Health: Explore patterns of global health financing*, Institute for Health Metrics and Evaluation, 2025.
[14] *Michael O'Grady et al., Global tech market forecast, 2024 to 2029*, Forrester Research, February 11, 2025.

2 Charting a new path: The impact of scaling proven health interventions

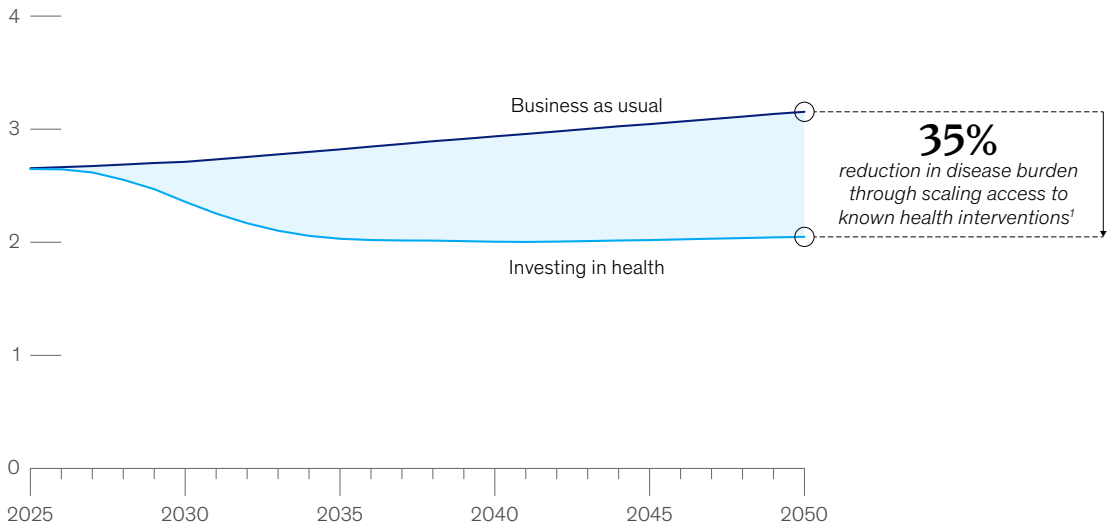
To evaluate the transformative potential of health investments, MHI examined approximately 300 known, evidence-based, cost-effective interventions drawn from systematic reviews and clinical practice guidelines. These interventions span across 90 diseases and 27 risk factors, encompassing about 85 percent of the global disease burden. These interventions represent the achievable impact based on today's evidence, prior to any additional benefits from future innovations. Using this robust foundation, the incremental health impacts of scaling access to these proven interventions to an aspirational best-practice adoption level were modeled for each country (see sidebars "Methodology" and "Intervention adoption assumptions").

Our analysis shows that by 2050, scaling these interventions globally could reduce total disease burden by 35 percent, preventing 33 million premature deaths and averting more than 461 million years lived with disability annually. This represents a significant bending of the global disease burden curve, decreasing premature mortality and enhancing quality of life across diverse populations (Exhibit 5).

Exhibit 5

There is an opportunity to bend the disease burden curve.

Global disease burden, billions of disability-adjusted life years



[1]Includes ~300 proven cost-effective interventions. Cost-effectiveness threshold defined as 3× GDP per capita for each country, based on WHO definition.
Source: Global Burden of Disease Database, Institute for Health Metrics and Evaluation, 2021 (used with permission, all rights reserved); literature review of intervention efficacy and adoption across 500+ papers including *Lancet* and Cochrane reviews; McKinsey Health Institute Prioritizing Health Model

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The impact of scaling proven health interventions varies across income groups, reflecting differences in disease burden mix and gaps between current and aspirational best-practice intervention adoption rates, resulting in a health impact of 33 percent among higher-income countries and 38 percent among lower-income countries.[15]

[15] Higher-income countries include high- and upper-middle-income countries, and lower-income countries include lower-middle and low-income countries, as per the World Bank's country income classification.

Methodology

In this report, the McKinsey Health Institute (MHI) examines global disease burden trends and assesses the potential health and economic gains from scaling proven, cost-effective interventions. The analysis builds on the McKinsey Global Institute's 2020 report, "Prioritizing health: A prescription for prosperity," extending its findings with updated data, methodology, and a broader set of interventions. It also reflects how the global public health landscape has changed over six years, with the enduring impact of the COVID-19 pandemic, the surge in metabolic health innovation exemplified by GLP-1 (glucagon-like peptide-1) drugs, and ongoing advancements across a wide range of health interventions.

The "Prioritizing Health" model evaluates the potential to reduce the global burden of disease by scaling access to proven cost-effective health interventions and estimates the resulting impacts on the global economy of that reduced burden.

Model overview:

Disease burden analysis: The model leverages the 2021 Global Burden of Disease (GBD) data set from the Institute for Health Metrics and Evaluation (IHME) to analyze the burden of approximately 90 diseases, which account for 85 percent of the global disease burden, and 27 risk factors, representing 98 percent of the risk-attributable burden. It estimates the potential reduction in disease burden by scaling proven health interventions to aspirational best-practice adoption levels.

Intervention identification and effectiveness estimation: A thorough literature review was conducted to identify scalable, evidence-based, cost-effective health interventions. Data on the effectiveness and current adoption rates of these interventions were extracted from more than 500 individual studies, covering approximately 300 interventions. Key sources included leading institutions such as the World Health Organization (WHO), the Disease Control Priorities Publications, and *The Lancet*. These sources, and a wide range of other peer-reviewed studies, informed the assumptions for each intervention.

Modeling disease burden reduction: The model represents the sequential implementation of health interventions year over year to quantify the potential reduction in disease burden for each condition-intervention pair over time. Adoption assumptions vary by intervention and reflect an aspirational scenario, illustrating what could be achieved over a 25-year period (2025–50) with gradual scaling.

Economic impact estimation: The potential economic benefits of reducing the disease burden are evaluated across several key dimensions, including reductions in premature mortality, disability, and the demands of informal caregiving, as well as improvements in productivity and future earnings for children. Together, these factors influence the size and productivity of the labor force, translating health advancements into tangible economic outcomes. The economic gains from lowering premature deaths and disability are based on previously calculated estimates of disease burden reduction. For productivity improvements, we drew on existing research that quantifies productivity losses associated with specific disease areas. Furthermore, the impact of informal caregiving was analyzed by estimating the economic benefits of increased labor force participation among caregivers and productivity enhancements for those already employed. Baseline projections for GDP, employment, and labor force participation rates were sourced from Oxford Economics and the International Labor Organization. These projections cover over 200 countries, broken down by five-year age groups and sex, spanning the period from 2025–50.

Cost and ROI: Implementation costs and economic returns are estimated using cost-per-disability-adjusted-life-year (cost-per-DALY averted) metrics from gold-standard databases such as Tufts Medical Center's Cost-Effectiveness Analysis Registry and WHO-CHOICE. Where data was unavailable from these two databases, we used estimates from other peer-reviewed sources. For the remaining interventions, the cost per DALY was estimated for each country income group using typical ratios in costs identified in studies examining costs across all country income groups. Cost per DALY for each intervention-country pair was then estimated using the identified country income group estimates and the World Bank's health price index. Using the total DALYs averted by each intervention in each country, the total cost of scaling interventions was estimated, and economic return was calculated as GDP uplift divided by the total cost of scaling interventions.

The MHI analysis focuses on cost-effective interventions. Recognizing that this threshold varies across regions and countries, we have applied the existing WHO cost-effectiveness threshold to identify the interventions to include in our analysis. The WHO threshold considers an intervention cost-effective in a given country if the cost per DALY averted is less than three times that country's GDP per capita. MHI acknowledges that this

Methodology (continued)

benchmark has limitations. The WHO itself has since moved away from using a single global threshold, given concerns around its applicability across diverse economic and health system contexts. However, in the absence of a universally accepted alternative suitable for global comparisons, we apply this standard as a known and easily interpretable benchmark.

Limitations of our analysis

A number of limitations are inherent in attempts to understand how global health could be improved through scaling known interventions and what the benefits could be in 25 years. These arise from uncertainties surrounding the evolution of the global disease burden, the availability and effectiveness of different interventions in diverse populations, and the impact of improvements in health on society and the economy. We manage these uncertainties in each step of our analysis in the following ways:

— *The evolution of the disease burden.* We rely on disease burden forecasts provided by IHME, which maintains the most comprehensive database of the global disease burden. Forecasts of the global disease burden are inherently uncertain, and health shocks and other political events may affect forecasts, such as any additional mortality that may be associated with declining global development assistance. These potential impacts are not yet reflected in current IHME disease burden forecasts, which do not account for additional mortality associated with declining global development assistance.[1]

— *The availability and effectiveness of interventions.* MHI's estimates are a snapshot of a very large scientific evidence base that is constantly evolving, often inconclusive, and uneven (in quantity and quality) across disease areas and specific interventions. In addition to the uncertainty inherent in the underlying evidence and our interpretation and application of it, other aspects of our methodological approach, such as the choices we have made in the sequencing of interventions, influence our findings. We have reduced these risks by sharing and reviewing our approach and interim results with academic and clinical experts at all stages of the research process.

— *Economic potential.* In the economic analysis, we make assumptions about the labor market choices people can and do make if health benefits were realized. Importantly, we make assumptions about rates of participation in the labor force for groups at different ages and in different health states. These assumptions are grounded in evidence, such as statistics on current and historic rates of labor force participation by age group, country, and health status. Another key assumption was that the labor market could fully absorb additions to the workforce at average levels of productivity. While GDP provides a consistent framework for estimating the economic impact of improved health, it does not capture all dimensions of societal well-being. It especially undervalues unpaid caregiving and household work—activities disproportionately carried out by women—and omits social, environmental, and community-level contributions that also underpin prosperity.

[1] Andrea Ferreira de Silva et al., "Impact of two decades of humanitarian and development assistance and the projected mortality consequences of current defunding to 2030: retrospective evaluation and forecasting analysis," *Lancet*, February 2, 2026.

While this analysis considers the impact of sustained investments over decades, it is important to recognize that some health interventions can yield benefits far more quickly. For example, universal access to safe drinking water could save an estimated three million lives every year, and light physical exercise can lower the risk of a repeat cardiac event by 50 percent within a year, illustrating how targeted health investments can deliver immediate and profound health benefits.[16]

[16] Jonathan Atteberry, "What if everyone had access to clean water?," HowStuffWorks, April 16, 2024; "Even a little daily activity may lower heart, death risks for heart attack survivors," American Heart Association, May 19, 2025.

Intervention adoption assumptions

The model aims to estimate the incremental impact of scaling up proven cost-effective health interventions relative to a "business as usual" baseline. Adoption assumptions are derived from the difference between current adoption levels and aspirational target adoption levels. Current adoption rates are estimated for each intervention and country income archetype using the best available evidence and were reviewed and validated by subject matter experts. Two scenarios were developed to estimate target adoption rates:

— *Aspirational best-practice scenario:* The health and economic impacts presented in this report are based on aspirational best-practice adoption rates for each intervention. These represent realistic estimates of the share of the addressable population that could be reached under optimal implementation, where barriers such as awareness, access, and adherence are largely overcome, while structural constraints such as socio-cultural factors, logistical challenges, and out-of-pocket costs are still acknowledged. Estimates are grounded in clinical evidence, expert judgment, and international benchmarks rather than assuming a theoretical 100 percent coverage scenario. For example, projected uptake of GLP-1 (glucagon-like peptide-1) drugs by 2050 is based on the current population-level adoption of statins, reflecting expert views that GLP-1 adoption may follow a similar trajectory. Estimated adoption rates for screening, vaccines, and preventive medicines are assumed to reach 95 percent, consistent with readily available national statistics.

— *Theoretical maximum scenario:* In contrast, the theoretical maximum scenario assumes full coverage and perfect adherence (100 percent target adoption rate) across all eligible populations. Under these ideal conditions, our model estimates that 1.5 billion disability-adjusted life years—representing about 50 percent of the total disease burden—could be averted. This highlights the substantial remaining unmet need and underscores the imperative for breakthrough innovations and novel treatment approaches.

Health impact, by condition

The impact of scaling proven health interventions differs across condition groups, shaped by disease burden, treatment availability, efficacy, and the gap between current practice and best-practice standards. Tackling metabolic and behavioral risks, combined with new medications, presents the strongest opportunities to reduce the growing NCD burden. Within NCDs, chronic respiratory diseases, mental disorders, and cardiovascular conditions offer the greatest potential for impact (see sidebars "Metabolic health deep dive" and "Brain health deep dive"). Among communicable diseases, maternal and neonatal disorders, enteric infections, and nutritional deficiencies represent the areas of highest impact, particularly in low-income settings.

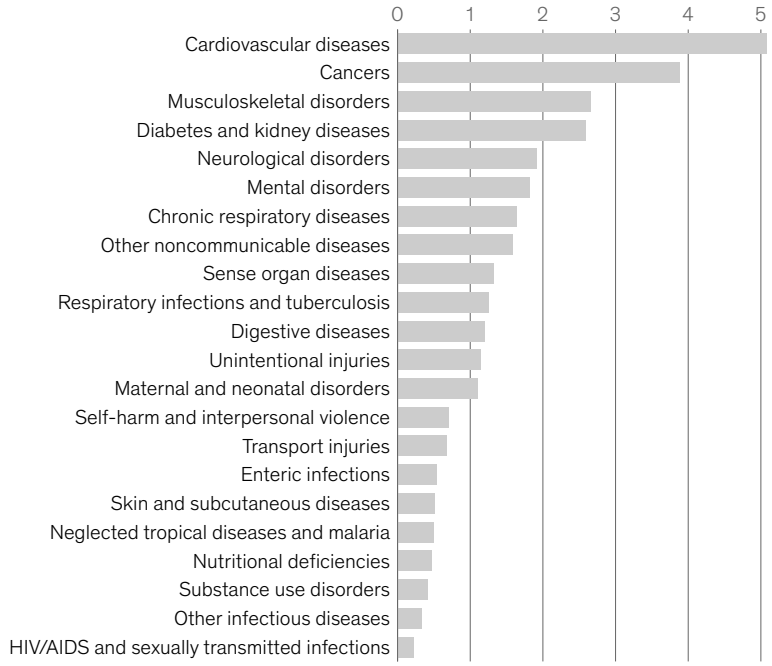
Despite advances in medical innovation, many interventions only partially mitigate conditions—by slowing progression (for example, diabetes management) or reducing onset risk (for example, hypertension control)—rather than offering cures. This leaves meaningful scope for breakthrough innovations and new treatments in areas such as neurodegenerative diseases, cancers with poor survival rates, advanced cardiovascular disease, and rare genetic or autoimmune disorders, where effective disease-modifying therapies remain limited.

Cardiovascular disease (for example, stroke or heart failure), cancers, and musculoskeletal disorders (for example, osteoarthritis or herniated discs) will lead in disease burden in 2050 (Exhibit 6a).

Exhibit 6a

Scaling access to known interventions can have significant impact across disease areas.

Global disease burden and potential reduction,[1] 2050, billions of disability-adjusted life years



[1]Includes ~300 proven cost-effective interventions. Cost-effectiveness threshold defined as 3× GDP per capita for each country, based on WHO definition.
Source: Global Burden of Disease Database, Institute for Health Metrics and Evaluation, 2021 (used with permission, all rights reserved); literature review of intervention efficacy and adoption across 500+ papers including *Lancet* and Cochrane reviews; McKinsey Health Institute Prioritizing Health Model

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Metabolic health deep dive

Society's understanding of metabolic health has grown rapidly over the past five years and is now being recognized as a key factor in a wide range of conditions such as cancers, diabetes, and chronic kidney disease, among others.[1]

Metabolic health—defined by the proper regulation of blood sugar, cholesterol, blood pressure, cardiovascular function, and kidney health—is foundational to human and economic well-being. Today, poor metabolic health contributes to an estimated 469 million disability-adjusted life years (DALYs) annually worldwide.

Poor metabolic health—closely linked to obesity—continues to rise across all income levels, reflecting both behavioral and structural drivers that are difficult to address at scale.[2] While GLP-1 (glucagon-like peptide-1) therapies offer a promising breakthrough for diabetes and weight management, medication alone can't reverse the trend.[3]

Scaling proven interventions for metabolic health that include improved nutrition and diets, active lifestyles, and healthier environments could avert 171 million DALYs and contribute up to $1.6 trillion to the global economy by 2050.

The McKinsey Health Institute's report "The path toward a metabolic health revolution" highlights five major shifts required to achieve metabolic health for all: advancing scientific understanding of metabolic health, improving transparency through better measurement and tracking, using technology for personalized interventions, aligning economic incentives to make metabolic health more investable, and driving societal change through education and community engagement.

Together, these shifts represent a comprehensive framework for transforming how societies approach metabolic health—integrating science, policy, and social action to create a healthier, more productive global population.

[1] Erind Gjermeni et al., "The impact of dietary interventions on cardiometabolic health," *Cardiovascular Diabetology*, 2025, Volume 24, Number 234.
[2] "*The Lancet*: More than half of adults and a third of children and adolescents predicted to have overweight or obesity by 2050," Institute for Health Metrics and Evaluation news release, March 3, 2025.
[3] Hon Jen Wong et al., "Efficacy of GLP-1 receptor agonists on weight loss, BMI, and waist circumference for patients with obesity or overweight: A systematic review, meta-analysis, and meta-regression of 47 randomized controlled trials," *Diabetes Care*, 2025, Volume 48, Number 2; "WHO issues global guideline on the use of GLP-1 medicines in treating obesity," WHO, December 1, 2025.

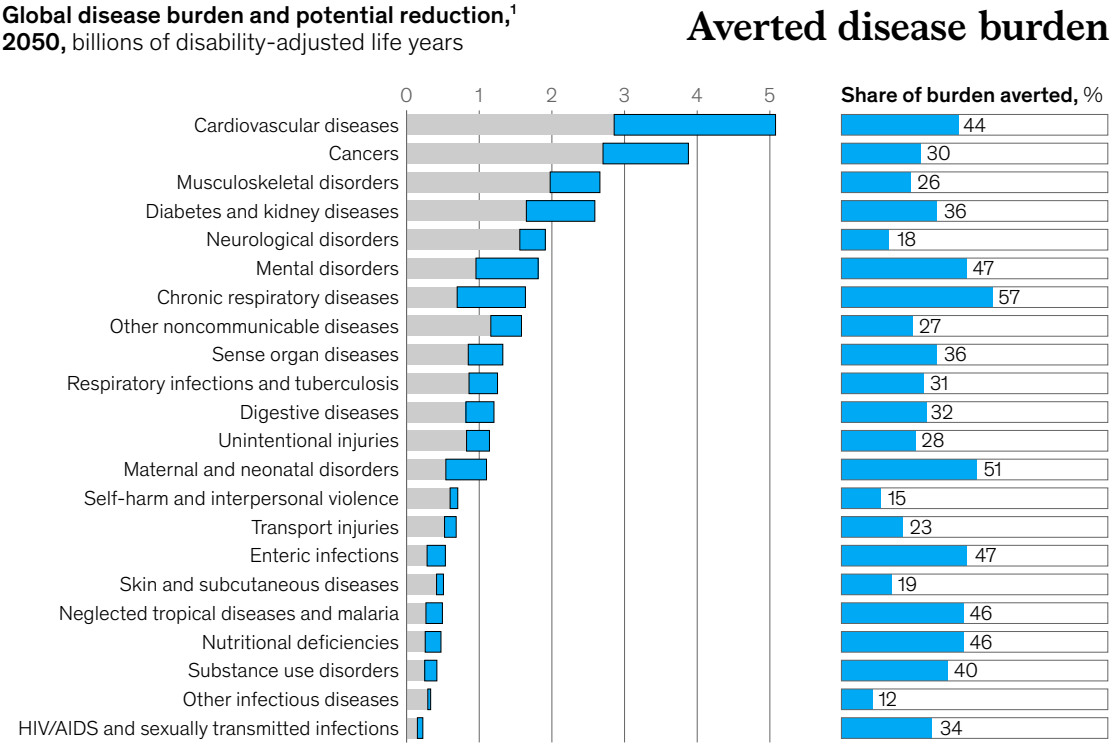
Scaling proven interventions for metabolic health that include improved nutrition and diets, active lifestyles, and healthier environments could avert 171 million DALYs and contribute up to $1.6 trillion to the global economy by 2050.

More than half the disease burden for chronic respiratory diseases, such as asthma, and maternal and neonatal disorders, such as preterm birth, could be averted through interventions (Exhibit 6b).

Exhibit 6b

Scaling access to known interventions can have significant impact across disease areas.

Global disease burden and potential reduction,[1] 2050, billions of disability-adjusted life years



[1]Includes ~300 proven cost-effective interventions. Cost-effectiveness threshold defined as 3× GDP per capita for each country, based on WHO definition.
Source: Global Burden of Disease Database, Institute for Health Metrics and Evaluation, 2021 (used with permission, all rights reserved); literature review of intervention efficacy and adoption across 500+ papers including *Lancet* and Cochrane reviews; McKinsey Health Institute Prioritizing Health Model

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Designing scalable impact: Intervention types and delivery settings

Realizing the full potential of scaling proven health interventions requires thoughtful consideration of the types of interventions, the settings in which they are delivered, and the key enablers that ensure effective and sustained scale-up.

Types of interventions

Health interventions can be broadly categorized into three types:

— *Population-level prevention* focuses on reducing health-related risks through broad measures that shape the physical and social environment or influence community behaviors, often through policy and regulation changes (for example, air quality controls, tobacco controls).

Brain health deep dive

Brain health conditions—including mental, substance use, and neurological disorders—represent a major and rising global challenge, accounting for an estimated 626 million disability-adjusted life years (DALYs) in 2025.[1] This represents nearly one-quarter of the total global disease burden, reflecting the direct effects of brain health conditions and their strong links to other noncommunicable diseases (NCDs). Despite this scale, notable funding gaps exist. For example, only about 2 percent of global healthcare funding is dedicated to mental health, resulting in an annual funding gap of $200 billion to $350 billion.[2] This underinvestment is especially significant because mental health conditions are the most prevalent in the younger working-age population, shaping its impact on the broader economy.

Task-sharing, a proven, evidence-based approach to addressing workforce shortages by delegating specific healthcare tasks to trained nonspecialists, has shown strong potential in improving brain health outcomes. The McKinsey Health Institute estimates that task-sharing providers could help 660 million people living with untreated mild or moderate mental health conditions globally. Assuming that the efficacy of task sharing is similar to that of counseling and other talk therapies, implementing task sharing could regain 18.6 million healthier years of life and contribute approximately $350 billion to global GDP.[3]

Increasingly, investment in the brain at an individual, organizational, and societal level is being recognized as an economic asset, a term known as "brain capital." A range of approaches already exists to support such an investment. The Coalition for Mental Health Investment has identified a variety of public and private sector financing mechanisms that can be used to close the investment gap and support relevant initiatives. These include traditional investing (for example, grants, government incentives, angel investing) and innovative financing mechanisms (for example, forgivable loans, crowdfunding, impact bonds) that derisk investments in brain health.

[1] Brad Herbig, Erica Coe, Kana Enomoto, and Shekhar Saxena, *The new case for brain health: Scaling interventions for health and economic growth*, McKinsey Health Institute, September 22, 2025.
[2] Brad Herbig, Erica Coe, Kana Enomoto, and Pooja Tatwawadi, *Investing in the future: How better mental health benefits everyone*, McKinsey Health Institute, April 25, 2025.
[3] *McKinsey Health Institute LinkedIn blog,* "Can mental health task sharing help unlock a $350 billion opportunity?," blog entry by Pooja Kumar et al., July 21, 2025.

— *Individual-level prevention* and proactive care targets personal behavior change and health risk management at the individual level and is often delivered in clinical settings (for example, vaccines, smoking cessation support).

— *Therapeutic interventions* address health conditions after they have developed and aim to manage existing diseases (for example, cancer therapies, psychiatric medications).

Prevention is a central pillar of overall health impact. Together, population-level and individual-level prevention strategies could propel 65 percent of potential health impact (Exhibit 7). These prevention strategies are particularly effective because they can influence multiple health outcomes simultaneously. For example, tobacco control not only reduces the incidence of lung cancer but also lowers the risk of cardiovascular disease, chronic respiratory conditions, and several other cancers.[17] Similarly, vaccinations protect against a range of infectious diseases, often preventing outbreaks that could otherwise strain health systems. Improved nutrition supports immune function, reduces the risk of chronic diseases such as Type 2 diabetes and obesity, and promotes healthy development across the lifespan. Because of their broad, multifaceted benefits, most population-level prevention interventions tend to be highly cost-effective because they avoid disease altogether.

[17] *Smoking cessation: A report of the surgeon general – key findings*, US Department of Health and Human Services, 2020.

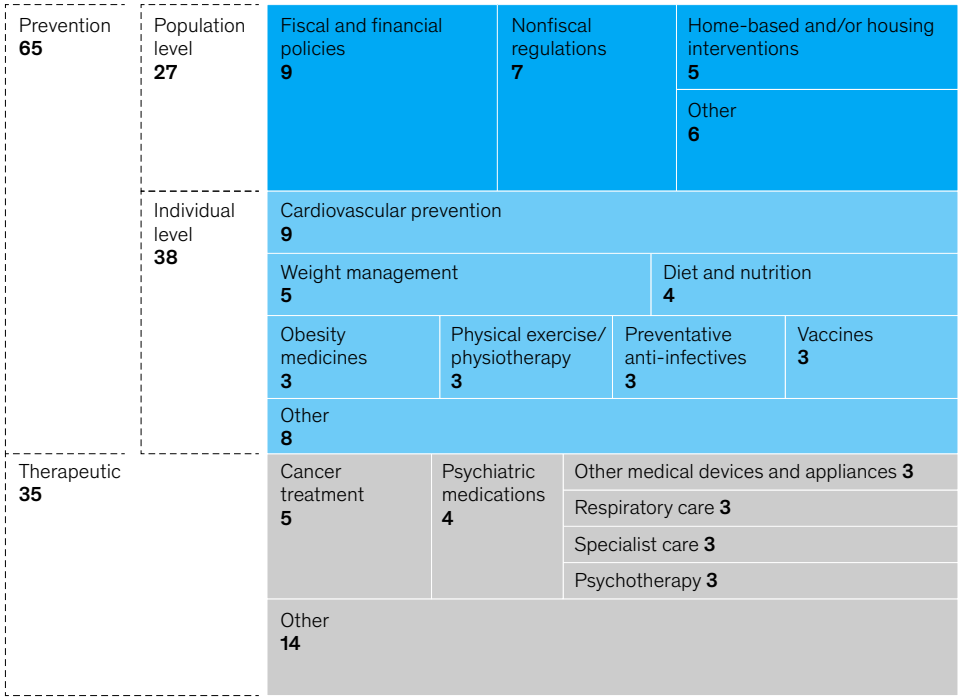
Individual behavioral and lifestyle choices also play a pivotal role in shaping health outcomes. Building healthy habits such as eating more fruits and vegetables, engaging in regular physical activity, and ensuring sufficient, high-quality sleep can substantially reduce the risk of chronic diseases, including cardiovascular conditions, diabetes, and certain cancers.[18] However, achieving widespread adoption of these healthy behaviors requires supportive, population-level interventions that make the healthy choice the easier choice. This analysis, therefore, focuses on evidence-based strategies that promote and facilitate healthier behaviors, such as front-of-package nutrition labeling or subsidies for healthy foods. Together with preventive care and screening initiatives within the healthcare system, these interventions form a strong foundation for improving health.

[18] "Fact sheet: Healthy diet," WHO, April 29, 2020; Michael R. Irwin, "Why sleep is important for health: A psychoneuroimmunology perspective," *Annual Review of Psychology*, 2015, Volume 66.

Exhibit 7

Prevention accounts for 65 percent of health improvement potential from known interventions.

Share of potential global disease burden reduction, by type,[1] 2050, %



[1]Includes ~300 proven cost-effective interventions. Cost-effectiveness threshold defined as 3× GDP per capita for each country, based on WHO definition.
Source: Global Burden of Disease Database, Institute for Health Metrics and Evaluation, 2021 (used with permission, all rights reserved); literature review of intervention efficacy and adoption across 500+ papers including *Lancet* and Cochrane reviews; McKinsey Health Institute Prioritizing Health Model

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Therapeutic interventions contribute the remaining 35 percent of health gains. They are essential for treating established conditions and improving outcomes for individuals with advanced disease. While more reactive in nature, they play a critical role in enhancing quality of life and extending survival as seen in patients receiving cancer treatments.

While both prevention and treatment are essential, scaling prevention presents the greatest opportunity for broad and sustainable improvements in health.

Intervention delivery settings

Understanding the types of care and the settings in which health interventions can be delivered is essential for designing systems that are both efficient and scalable, as well as for identifying the most effective implementation pathways (Exhibit 8).

About three-quarters of the total potential health impact could be achieved by appropriately scaling interventions delivered in primary care settings (for example, anti-hypertensives, maternal-nutrition strategies) and in specialty care settings (for example, early detection and management of cancers, surgeries, pharmacotherapy). Although some interventions can be delivered across multiple settings, nearly all these interventions are primarily delivered within formal health system settings, suggesting that expanded implementation within health systems could play a critical role in improving global health outcomes. This also indicates a clear opportunity for health systems to improve how care is delivered—boosting patient outcomes while keeping costs contained.

Public health interventions, such as tobacco controls and household stove swaps, could account for the remaining quarter of the total potential impact. An estimated 95 percent of this impact can be achieved outside the formal health sector—in settings such as schools, workplaces, community organizations, and through public policy measures. These nontraditional delivery channels can offer substantial opportunities to improve health by engaging with sectors not typically associated with healthcare delivery. Their relevance can be particularly pronounced in lower-income countries, where formal healthcare infrastructure is more limited and community-based interventions can have an outsize effect.[19]

[19] Iffat Nowrin et al., "Community-based interventions to prevent stroke in low and middle-income countries: A systemic review," *Health Sciences Review*, 2023, Volume 9.

Understanding the types of care and the settings in which health interventions can be delivered is essential for designing systems that are both efficient and scalable, as well as for identifying the most effective implementation pathways.

Realizing the full impact of scaled interventions depends as much on prevention and care delivery models as on the interventions themselves. Countries can reach similar health outcomes through distinct implementation models suited to their socio-economic realities, as illustrated by polio eradication efforts. India relied on intensive mass-vaccination campaigns, granular microplanning, and targeted community engagement to address scale, mobility, and mistrust.[20] Egypt, by contrast, achieved elimination primarily through consistently high routine immunization embedded in its national health system, complemented by targeted campaigns and strong surveillance.[21] This illustrates why how effective scaling depends less on replicating solutions and more on adapting delivery models to the local context.adapting delivery models to the local context could be more effective for scaling than simply replicating solutions.

[20] Roma Solomon, "Involvement of civil society in India's Polio eradication program: Lessons learned," *American Journal of Tropical Medicine and Hygiene*, October 2019, Volume 101.
[21] R. Bruce Alylward et al., "The eradication of poliomyelitis in Egypt: critical factors affecting progress to date," *Journal of Infectious Diseases*, February 1997, Volume 175.

Exhibit 8

Understanding care delivery settings is essential for scaling health impact.

Potential global disease burden reduction,[1] 2050, millions of disability-adjusted life years

[1]Includes ~300 proven cost-effective interventions. Cost-effectiveness threshold defined as 3× GDP per capita for each country, based on WHO definition.
Source: Global Burden of Disease Database, Institute for Health Metrics and Evaluation, 2021 (used with permission, all rights reserved); literature review of intervention efficacy and adoption across 500+ papers including *Lancet* and Cochrane reviews; McKinsey Health Institute Prioritizing Health Model

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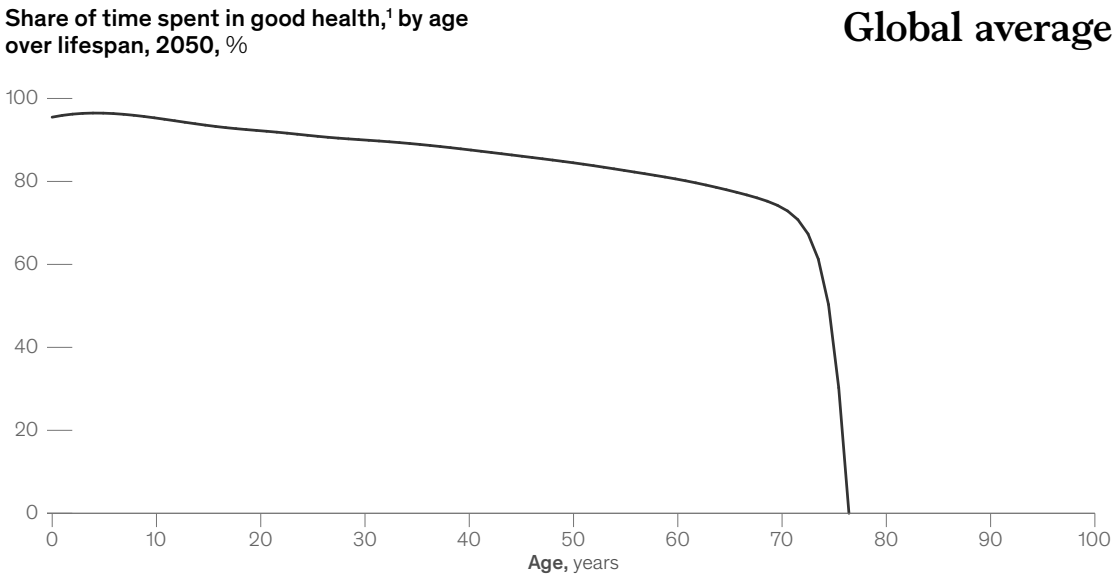
3 Implications for individuals: Improving lifespan and quality of life

Scaling proven health interventions could substantially extend both lifespan and health span. By 2050, global life expectancy could rise by an average of six years, with some countries achieving even larger gains. More important, the average health-adjusted life expectancy, the years lived free from disabling illness, could increase by up to nine years worldwide. These additional years of good health not only extend longevity but also enhance the quality of life throughout the entire lifespan, effectively "squaring the curve."

This chart shows the expected proportion of life spent in good health across the lifespan of an average individual in 2050, based on IHME's disease burden and life expectancy projections (Exhibit 9a).

Exhibit 9a

Scaling proven interventions can square the curve, extending both lifespan and health span.



[1]Estimated as 1 minus years lived with disability per capita, by 5-year age bands and life expectancy at birth.
Source: Global Burden of Disease Database, Institute for Health Metrics and Evaluation, 2021 (used with permission, all rights reserved)

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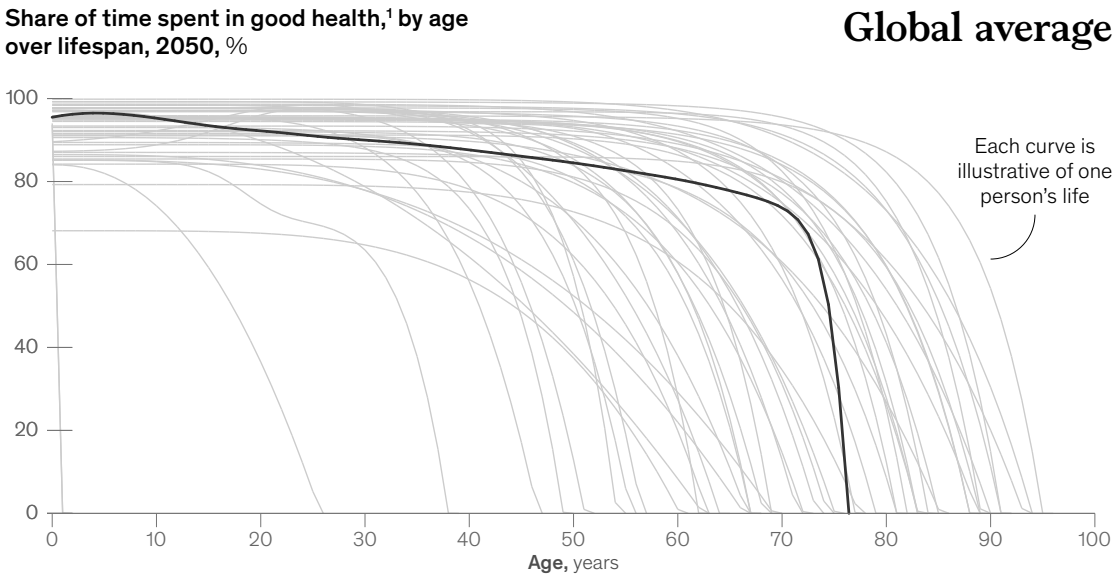
By 2050, global life expectancy could rise by an average of six years, with some countries achieving even larger gains.

The average health span curve reflects the lives of billions of people, each with their own unique health journey shaped by personal circumstances, choices, and conditions. This exhibit depicts illustrative examples of individuals experiencing poor health, showcasing their quality-of-life trajectories over the course of their lifespans (Exhibit 9b).

Exhibit 9b

Scaling proven interventions can square the curve, extending both lifespan and health span.

Share of time spent in good health,[1] by age over lifespan, 2050, %



[1]Estimated as 1 minus years lived with disability per capita, by 5-year age bands and life expectancy at birth.
Source: Global Burden of Disease Database, Institute for Health Metrics and Evaluation, 2021 (used with permission, all rights reserved)

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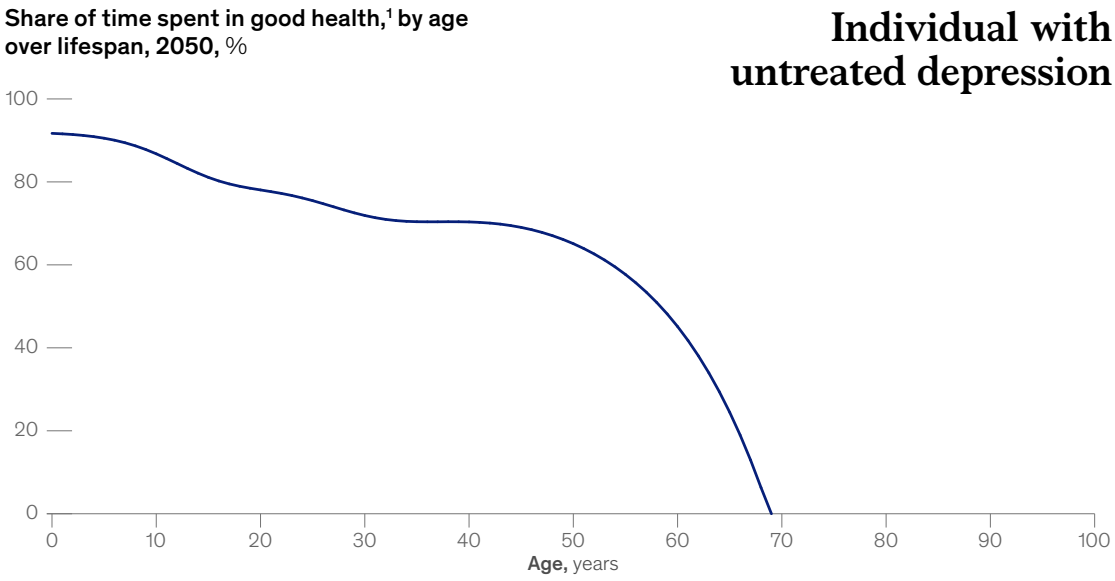
The average health span curve reflects the lives of billions of people, each with their own unique health journey shaped by personal circumstances, choices, and conditions.

For example, untreated depression in an individual could result in a significant drop in the percentage of time spent in good health throughout their lifespan (Exhibit 9c).

Exhibit 9c

Scaling proven interventions can square the curve, extending both lifespan and health span.



[1]Estimated as 1 minus years lived with disability per capita, by 5-year age bands and life expectancy at birth.
Source: Global Burden of Disease Database, Institute for Health Metrics and Evaluation, 2021 (used with permission, all rights reserved)

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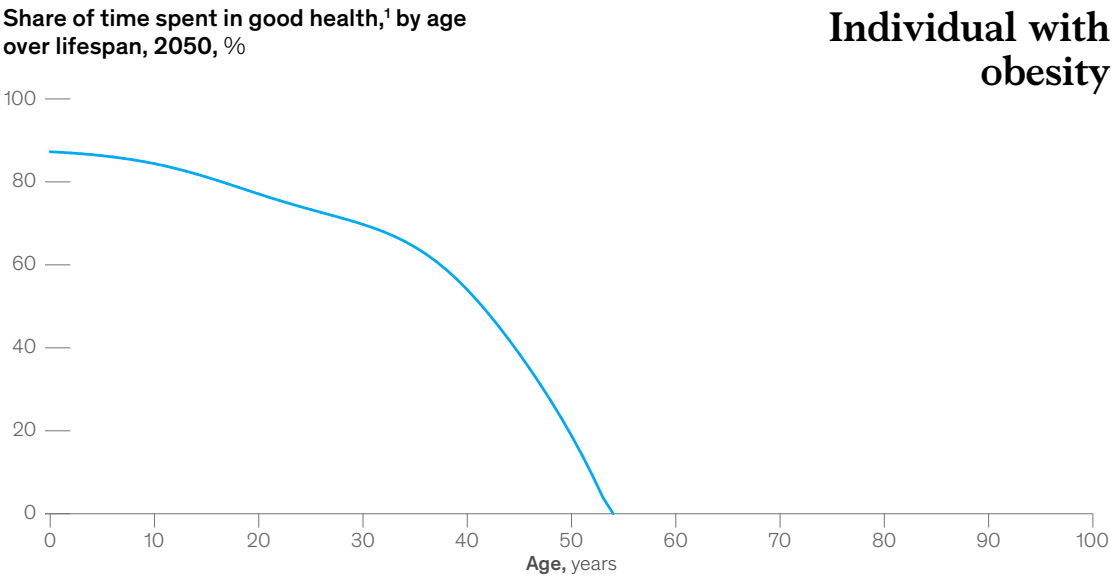
Untreated depression in an individual could result in a significant drop in the percentage of time spent in good health throughout their lifespan.

For another individual, suffering from obesity could not only decrease the proportion of time spent in good health but also could lead to a premature death due to heart failure (Exhibit 9d).

Exhibit 9d

Scaling proven interventions can square the curve, extending both lifespan and health span.



[1]Estimated as 1 minus years lived with disability per capita, by 5-year age bands and life expectancy at birth.
Source: Global Burden of Disease Database, Institute for Health Metrics and Evaluation, 2021 (used with permission, all rights reserved)

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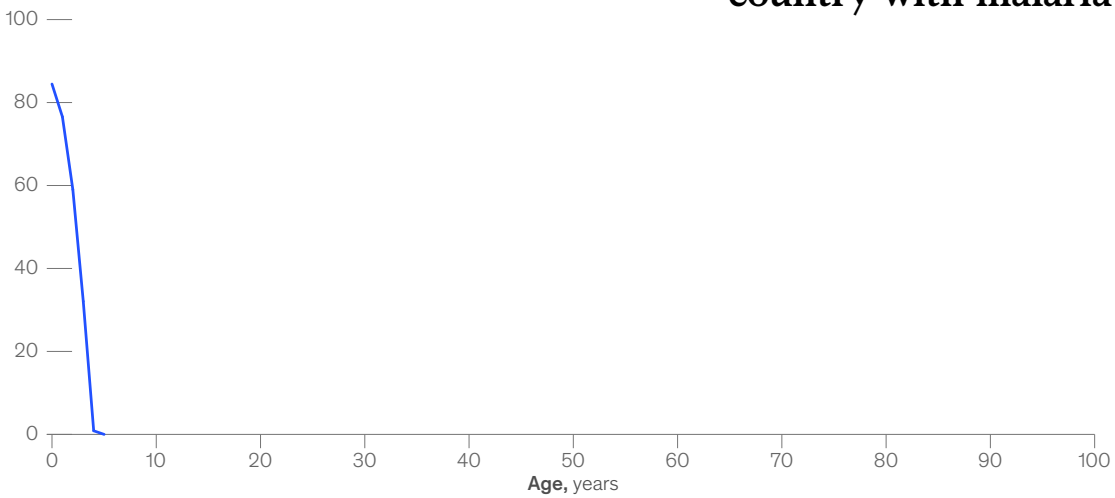
For another individual, suffering from obesity could not only decrease the proportion of time spent in good health but also could lead to a premature death due to heart failure.

In a low-income country, a child's life could be prematurely ended by malaria (Exhibit 9e).

Exhibit 9e

Scaling proven interventions can square the curve, extending both lifespan and health span.

Share of time spent in good health,[1] by age over lifespan, 2050, %



[1]Estimated as 1 minus years lived with disability per capita, by 5-year age bands and life expectancy at birth.
Source: Global Burden of Disease Database, Institute for Health Metrics and Evaluation, 2021 (used with permission, all rights reserved)

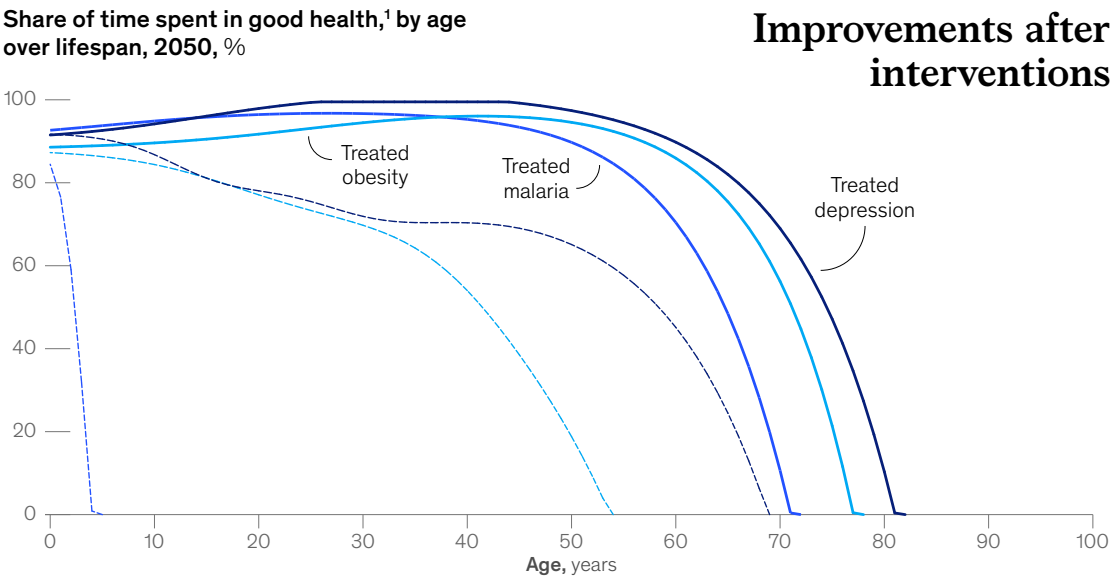
McKinsey & Company

In a low-income country, a child's life could be prematurely ended by malaria.

Expanding access to proven cost-effective interventions, such as psychotherapy, weight management programs, medications, and vaccines, could transform the lives of these individuals, allowing them to live longer, healthier lives. The exhibit illustrates how health span curves might change in these hypothetical scenarios (Exhibit 9f).

Exhibit 9f

Scaling proven interventions can square the curve, extending both lifespan and health span.



[1]Estimated as 1 minus years lived with disability per capita, by 5-year age bands and life expectancy at birth.
Source: Global Burden of Disease Database, Institute for Health Metrics and Evaluation, 2021 (used with permission, all rights reserved)

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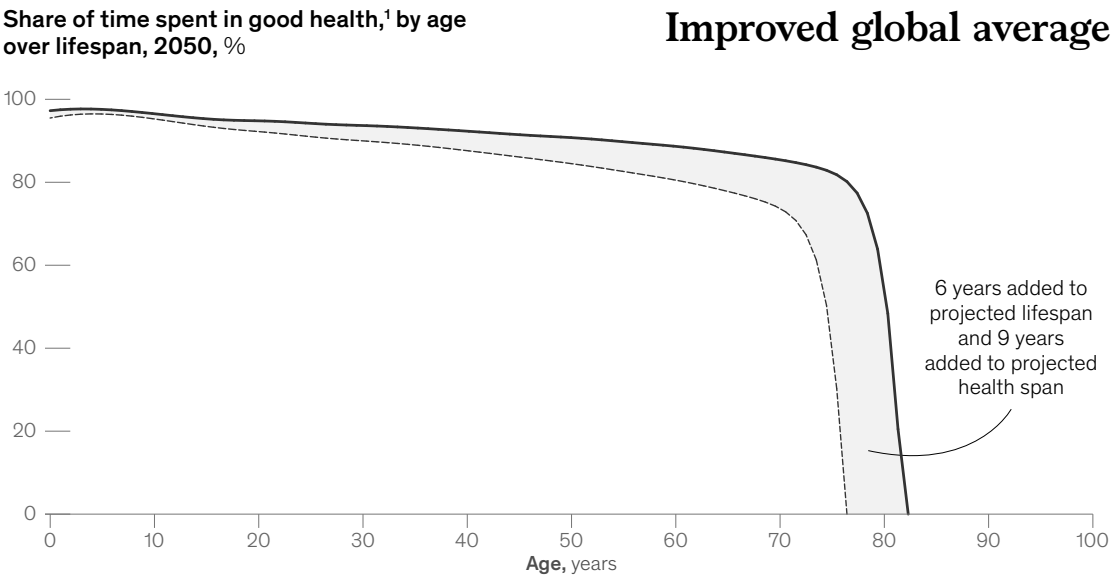
Expanding access to proven cost-effective interventions, such as psychotherapy, weight management programs, medications, and vaccines, could transform the lives of these individuals, allowing them to live longer, healthier lives.

Aggregating all individual experiences at a global-population level could result in lifting, extending, and squaring the health curve. This leads to more healthy days throughout life and increased life expectancy. On average, individuals could gain six years of life expectancy and nine more healthy years over their lifespan, equating to 18 additional healthy days each year (Exhibit 9g).

Exhibit 9g

Scaling proven interventions can square the curve, extending both lifespan and health span.



[1]Estimated as 1 minus years lived with disability per capita, by 5-year age bands and life expectancy at birth.
Source: Global Burden of Disease Database, Institute for Health Metrics and Evaluation, 2021 (used with permission, all rights reserved)

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Quality of life improvements are expected to be especially pronounced in low-income countries, where uptake and implementation of existing interventions are still expanding. In these settings, a healthy lifespan could increase by nearly 11 years, reflecting the opportunity to reduce both infectious and NCD burdens. Many conditions that are less common in higher-income settings, including infectious diseases such as malaria, HIV/AIDs, and diarrheal diseases, remain prevalent in many low-income countries. Scaling interventions in these areas can accelerate the closure of these gaps, delivering rapid and meaningful health gains while also laying the foundation for sustained progress against emerging health challenges. This dual burden presents a powerful case for targeted investment, which could yield substantial returns for both human well-being and economic growth.

4 Implications for the economy: How improved health drives economic outcomes

Improved health is not only a social good but also a powerful engine for economic development. Research has demonstrated a strong and reciprocal relationship between better health outcomes and enhanced economic performance.[22] This relationship is bidirectional: While economic growth can lead to better health outcomes through improved living conditions and health services,[23] health itself is a form of human capital that fuels economic development by enabling individuals to live longer, work more productively, and contribute more consistently to society.[24]

A healthier society leads to a more robust and resilient economy in many ways. To estimate the economic impact of better health, MHI focused its analysis on labor force effects, including enabling greater labor force participation and enhancing individual productivity, identifying six key levers through which better health drives economic gains.

Increased labor force participation involves the following:

— *Fewer early deaths:* Reducing premature mortality literally means a person stays alive for longer, allowing them to work, support their family, contribute to society, and live fuller lives.[25]

— *Fewer health conditions:* When chronic and acute diseases are prevented or effectively managed, people are more likely to be able to attend work consistently, reducing absenteeism. Enhanced health empowers them to participate more actively in economic activities, driving greater workforce efficiency and fostering sustained economic growth.[26]

— *Expanded labor force participation from informal caregivers:* In healthier populations, the need for informal caregiving, often provided by family members, significantly decreases.[27] This reduction can give those caregivers—the majority of whom are women—more time, energy, and resources to pursue paid employment, education, or entrepreneurial activities. Beyond the economic benefits of an expanded labor force,[28] this shift also yields important societal gains in promoting gender equity by alleviating the disproportionate caregiving burden on women and contributing to their economic empowerment.[29]

Enhanced productivity involves the following:

— *Increased productivity from better health:* Enhancing health has the potential to boost productivity by reducing presenteeism (reduced on-the-job performance due to illness) caused by chronic conditions such as musculoskeletal disorders (for example, osteoarthritis and lower-back pain) and mental disorders, including depressive and anxiety disorders, as well as substance use disorders.[30]

— *Higher-future-earnings potential for children:* Investments in early childhood health and nutrition and addressing adolescents' mental health challenges can lead to better educational attainment, cognitive

[22] Richard Horton et al., *Highlevel commission on health employment and economic growth: Final report of the expert group*, WHO, September 3, 2016.
[23] Xiao-Tong Niu, You-Cai Yang, and Yu-Cong Wang, "Does the economic growth improve public health? A crossregional heterogeneous study in China," *Frontiers in Public Health*, 2021, Volume 9.
[24] *Health, economic growth and jobs*, World Bank, April 17, 2025.
[25] Angela Y. Chang et al., "The economic value of reducing avoidable mortality," *Nature Medicine*, 2024, Volume 30, Number 11.
[26] Tam Vuong, Feifei Wei, and Claudia F. Beverly, "Absenteeism due to functional limitations caused by seven common chronic diseases in US workers," *Journal of Occupational and Environmental Medicine*, 2015, Volume 57, Number 7.
[27] William E. Haley and Joanne Elayoubi, "Family caregiving as a global and lifespan public health issue," *Lancet Public Health*, January 2024, Volume 9, Number 1.
[28] Ingo W. K. Kolodziej, Arndt R. Reichert, and Hendrik Schmitz, "New evidence on employment effects of informal care provision in Europe," *Health Services Research*, 2018, Volume 53, Number 4.
[29] *The impact of care responsibilities on women's labour force participation*, International Labour Organization, October 2024.
[30] Lars Bernfort et al., "Supervisor ratings of productivity loss associated with presenteeism and sick leave due to musculoskeletal disorders and common mental disorders in Sweden," *WORK: A Journal of Prevention, Assessment & Rehabilitation*, 2021, Volume 68, Number 4.

development, and social-emotional skills. These early advantages translate into higher employment rates and greater lifetime earnings.[31]

— *Enhanced productivity of informal caregivers:* Improved health reduces caregiving burdens, enabling former caregivers to participate more fully and productively in the workforce, no longer constrained by the physical and emotional demands of care.[32]

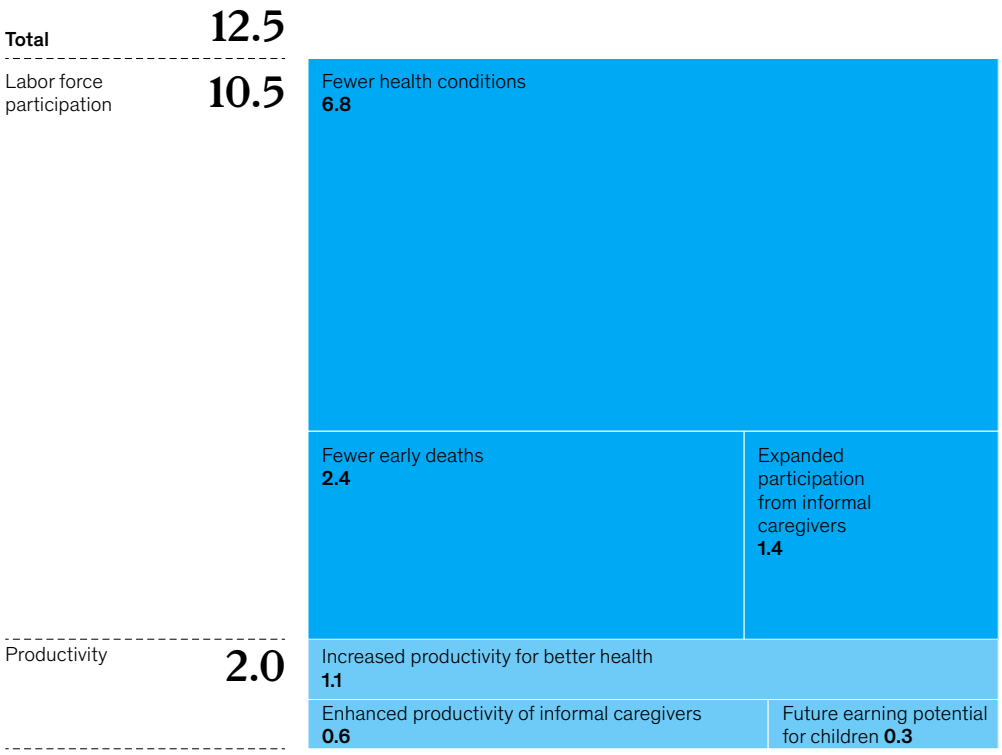
By quantitatively modeling the six economic levers linked to improved health, MHI estimates that enhancing global health could generate approximately 288 million additional full-time equivalent work-years by 2050, more than twice the current United States's labor force and equivalent a 4 percent increase in the current global labor force participation rate.[33] This expansion in productive labor could add $12.5 trillion to global GDP, representing an increase of about 7 percent over baseline economic projections (Exhibit 10). Notably, the vast majority of this economic gain (about 85 percent) is driven by increased labor force participation.

[31] Arindam Nandi et al., "The human capital and productivity benefits of early childhood nutritional interventions," from *Child and Adolescent Health and Development*, International Bank for Reconstruction and Development and World Bank, November 2017.
[32] Grant R. Martsolf et al., "Work performance among informal caregivers: A review of the literature," *Journal of Aging and Health*, 2020, Volume 32, Number 9.
[33] "Full time employment," Trading Economics, September 2025.

Exhibit 10

Improved health could boost global GDP by $12.5 trillion in 2050.

Global economic impact of scaling interventions, 2050,[1] $ trillion



Note: Figures may not sum, because of rounding.
[1]Includes ~300 proven cost-effective interventions. Cost-effectiveness threshold defined as 3× GDP per capita for each country, based on WHO definition.
Source: Global Burden of Disease Database, Institute for Health Metrics and Evaluation, 2021 (used with permission, all rights reserved); literature review of intervention efficacy and adoption across 500+ papers including *Lancet* and Cochrane reviews; McKinsey Health Institute Prioritizing Health Model

McKinsey & Company

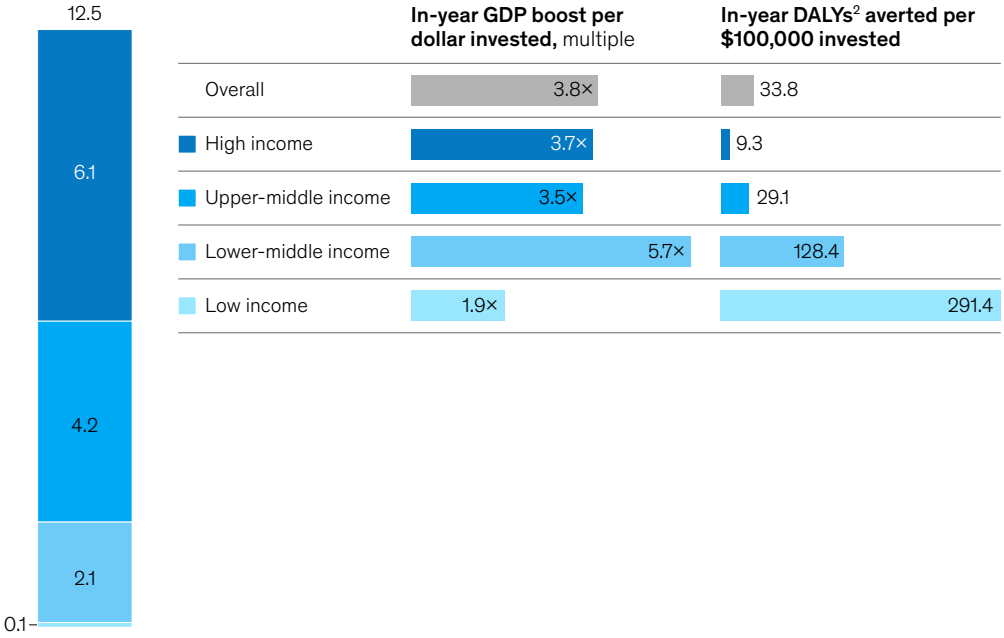
Achieving this level of global health improvement would require substantial investment estimated at approximately $3.3 trillion annually by 2050, representing about 16 percent of projected global healthcare spending in 2050 ($20.5 trillion). While this represents a meaningful commitment, the returns are equally substantial. Not all current health spending delivers commensurate health gains, and reallocating resources toward more effective interventions could substantially increase economic impact. For every dollar invested, an estimated $4 in economic benefit is generated by scaling cost-effective interventions, reflecting a fourfold return on investment (Exhibit 11).

Higher-income countries account for a larger share of the absolute economic impact (82 percent) largely because they represent approximately 86 percent of global GDP. However, their economic ROI in health interventions is not disproportionately higher compared with other income groups. In fact, lower-middle-income countries are projected to achieve the highest return on investment, with an estimated sixfold return from implementing cost-effective health interventions. Low-income countries show the lowest return, at 1.9 times, which may reflect structural challenges such as limited health infrastructure and higher relative implementation costs. These factors can constrain the scalability and affordability of interventions, especially given the smaller economic base of these countries; however, targeted investments still present a significant opportunity for impactful health improvements and long-term economic growth.

Exhibit 11

Improving health globally could yield a fourfold return on investment.

Global economic impact of scaling interventions, by country income archetype, 2050,[1] $ trillion



[1]Includes ~300 proven cost-effective interventions. Cost-effectiveness threshold defined as 3× GDP per capita for each country, based on WHO definition.
[2]Disability-adjusted life years.
Source: Global Burden of Disease Database, Institute for Health Metrics and Evaluation, 2021 (used with permission, all rights reserved); literature review of intervention efficacy and adoption across 500+ papers including *Lancet* and Cochrane reviews; McKinsey Health Institute Prioritizing Health Model

McKinsey & Company

The economic return on health investments is not uniform across all countries or interventions. Each country has a unique demographic, economic, and epidemiological profile that shapes which health challenges are most pressing and which solutions are most effective and affordable. For example, investing in newer obesity or chronic obstructive pulmonary disease medicines may generate substantial economic returns in high-income countries where health systems can absorb the high cost of these drugs. However, the same intervention may offer smaller economic returns in lower-income countries where the costs of such medications would be prohibitive.

It is important to note that this analysis is not intended to suggest that countries should avoid investing in interventions with lower economic returns. Many such interventions are essential for promoting equity and building long-term resilience, even if their immediate economic benefits are limited. Instead, the goal is to support evidence-based decision-making by offering a clearer understanding of the health and economic impacts of investments in health, enabling policymakers to allocate resources in ways that best address the diverse needs of their populations.

How to get started

Crucially, scaling cost-effective interventions does not require an all-or-nothing approach. By prioritizing a targeted set of high-impact actions, countries can capture a substantial share of the total economic and health benefits at a fraction of the total cost.

The WHO's "Best Buys" provide a globally recognized set of interventions that are proven, cost-effective, and feasible across income levels. These include measures such as tobacco and alcohol taxation, hypertension control programs, salt and sugar reduction policies, vaccination campaigns, and early detection of noncommunicable diseases. Prioritizing these interventions can deliver 17 percent of the health benefits at a fraction of the cost ($242 billion or 7 percent) with a return of 6:1.

While the cost-effectiveness of interventions varies widely, our analysis highlights those that deliver the greatest impact per dollar spent, offering policymakers a practical framework to prioritize investments with the strongest combined health and economic returns in their national contexts (Exhibit 12).

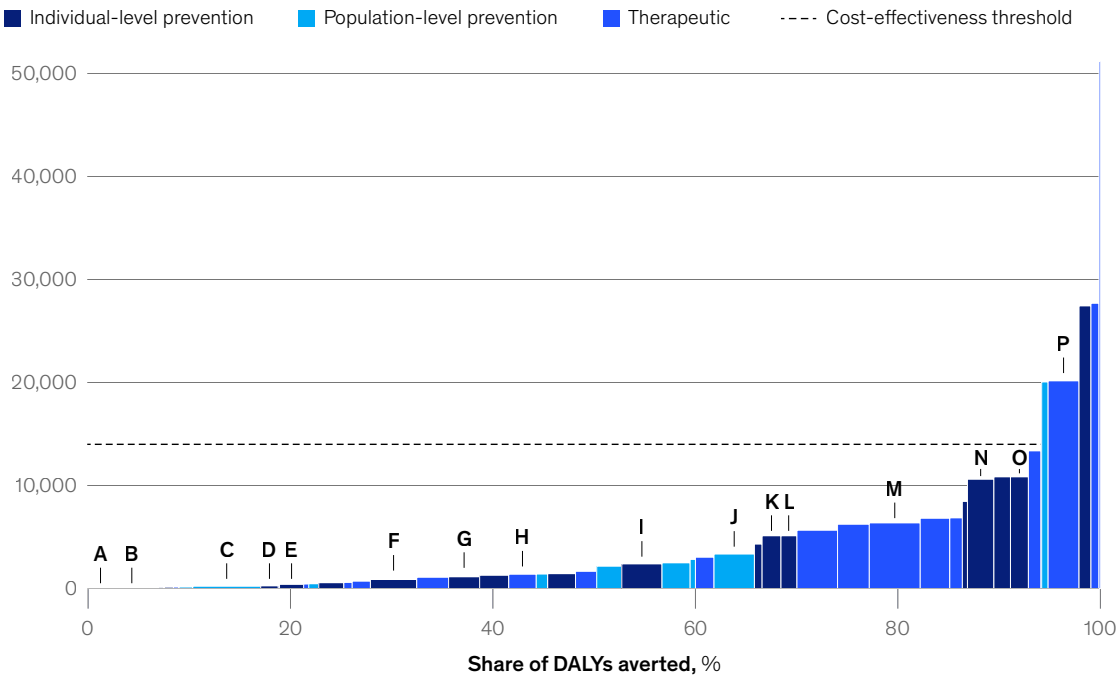
Many of the most valuable health investments are both affordable and widely available, yet they do not currently reach all who could benefit from them. For instance, the routine use of antihypertensive medications prevents costly complications such as stroke and heart disease, resulting in substantial long-term savings. Fiscal policies that discourage harmful behaviors, such as tobacco and alcohol use, also demonstrate particularly high economic and social returns. Tobacco taxation, for example, has a return on investment of 35 to 1, generating immediate fiscal revenue while reducing disease burden and mortality associated with tobacco use. Similarly, alcohol taxation delivers an estimated eight-to-one return, curbing harmful consumption while strengthening fiscal capacity for reinvestment in prevention and treatment.

By prioritizing a targeted set of high-impact actions, countries can capture a substantial share of the total economic and health benefits at a fraction of the total cost.

Exhibit 12

Preventive and lifestyle interventions have high health and economic returns.

Cost per disability-adjusted life years (DALYs) averted, global, 2050,[1] $



A Maternal nutrition strategy
B Household stove swaps
C Tobacco controls
D Enhanced training, support, and regulation for professional midwives
E Diabetes prevention program
F Antihypertensives
G Vaccines (eg, HPV, malaria)
H Psychotherapy
I Cardiovascular prevention
J Air quality controls
K Glucagon-like peptide-1 (GLP-1s) for obesity
L GLP-1s to reduce diabetes risk
M Cancer treatment
N Weight management
O Physical exercise therapy for low-back pain
P Respiratory medicines

Note: Cost per disability-adjusted life year (DALY) and cost-effectiveness thresholds are calculated as weighted averages of country-level values. Interventions are ordered in ascending order of cost for every healthy life year. The higher the disease burden reduction potential, the larger the width under each intervention. Analysis includes ~300 proven cost-effective interventions. Cost-effectiveness threshold defined as 3× GDP per capita for each country, based on WHO definition.
Source: Global Burden of Disease Database, Institute for Health Metrics and Evaluation, 2021 (used with permission, all rights reserved); literature review of intervention efficacy and adoption across 500+ papers including *Lancet* and Cochrane reviews; McKinsey Health Institute Prioritizing Health Model

McKinsey & Company

These examples demonstrate how well-designed health investments can be fiscally self-reinforcing, producing near-term fiscal gains alongside long-term improvements in productivity and well-being. In the face of constrained budgets and difficult choices, embedding such interventions within broader health and economic strategies can enable governments to pursue strong economic returns while advancing population well-being and accelerating progress toward better health, increased economic resilience, and sustained growth.

5 How to accelerate a healthier future

This research builds on and strengthens the growing body of evidence that makes a clear and urgent case for investing in health as a driver of social and economic progress. Yet action lags behind evidence. Resources are finite, and decision-makers face constant trade-offs between urgent demands and longer-term investments whose benefits may not be immediately visible. As a result, high-value interventions remain underused, and much of health's potential for economic and social progress goes untapped.

But knowing *what* to do is only the first step. *How* to implement a high-value set of interventions is often the harder part—but also one that we have made progress against in the past decade. Stakeholders now have a far better understanding of what it takes to create scaled change in healthcare delivery, powered by advances in data and technology. These tools, alongside burgeoning use cases in AI, are beginning to transform how health systems target resources, predict outcomes, and scale what works, fueling new levels of efficiency and impact. At the same time, a growing base of proven case studies, new platforms for global collaboration, and more effective channels for sharing best practices are enabling faster learning cycles.

Translating this momentum into sustained progress requires changing some of the core structures of the healthcare system. Progress on implementing scaled change depends on a health workforce that is large enough and appropriately skilled, supported by care delivery platforms and tools that combine physical infrastructure, digital technology, and community-based models to reach people where they are. It also requires foundational capabilities such as supply chains, financing, and incentive structures, as well as data and information systems, to ensure providers have the medicines, facilities, and insights needed to act earlier and more effectively.

Against this backdrop, achieving better health for all will require three actions:

— aligning incentives to reward long-term investment in prevention

— unleashing multisectoral action to drive progress in health and beyond

— boosting efficiency of health spending to maximize outcomes

Together, these actions can help address the central challenge of our time: building health systems and societies that not only deliver care but also create massive population-wide health improvements, resilience, and shared prosperity.

1. Aligning incentives to reward long-term investment in prevention

Prevention is one of the highest-return investments a health system can make. The WHO and numerous economic evaluations show that preventive measures consistently deliver some of the highest returns on investment, earning their place in the WHO's "Best Buys" for health.[34]

Many of these investments are remarkably affordable. For example, studies estimate that scaling up access to affordable blood pressure treatment could avert millions of premature deaths over the next 25 years at a cost of less than five dollars per person per year.[35] Importantly, it is a myth that all preventive interventions take decades to deliver a measurable return. Hospital-initiated smoking cessation has been found to reduce

[34] *Tackling NCDs: Best buys and other recommended interventions for the prevention and control of noncommunicable diseases*, WHO, 2024.
[35] "First WHO report details devastating impact of hypertension and ways to stop it," WHO , September 19, 2023; Andrew E. Moran et al., "Building the health-economic case for scaling up the WHO-HEARTS hypertension control package in low- and middle-income countries," *Pan American Journal of Public Health*, 2022, Volume 46.

the risk of readmission and ED attendance within a month,[36] and many of the WHO "Best Buys" have been shown to produce measurable results within five years.[37]

Despite overwhelming evidence of near and long-term returns, preventative care remains chronically underfunded. Modifiable risk factors such as poor diet, tobacco use, physical inactivity, and harmful alcohol consumption account for well over 40 percent of the global disease burden. These risk factors are often framed as matters of individual choice, but in reality, they are deeply influenced by the environments in which people live, learn, and work—from food systems and urban design to marketing and social norms. Recognizing this overlap between personal behavior and societal structure reframes prevention as a shared responsibility.

Yet, most nations spend only a sliver of their health budgets on prevention. In the European Union, for example, after a temporary increase driven by the COVID-19 pandemic response, in 2023, preventive-care spending accounted for just 3.65 percent of total healthcare expenditures (€62.8 billion), returning to prepandemic levels.[38] Most OECD countries spend less than 2 percent of their health expenditure on prevention.[39] However, countries that spend more on prevention tend to achieve better health outcomes. Longitudinal evidence across OECD countries shows that sustained preventive spending is associated with lower mortality and longer life expectancy, highlighting a widening gap between what evidence shows works and how resources are allocated in practice.[40]

This disconnect is not driven by a lack of evidence, but by persistent structural barriers rooted in time frame challenges, including the following:

— *Attribution challenges:* Preventive interventions face attribution difficulties, the "counterfactual problem," because success means an illness did not occur. Unlike treatment, where outcomes are immediate and visible, prevention's effect is harder to quantify or value.[41] Prevention often generates broad trickle-down effects that unfold across time and sectors: Healthier populations foster more resilient communities, lower costs, greater productivity, and stronger economies. These diffused, system-wide benefits make prevention both more valuable and less measurable: the farther its impact extends, the harder it becomes to capture and credit in conventional evaluation frameworks.

— *Payment and operating model challenges:* Health systems were originally designed around treating illness rather than maintaining health.[42] Infrastructure, workflows, and professional roles are designed to respond to acute needs rather than sustain long-term well-being. Workforce composition and training of healthcare professionals are heavily oriented toward hospital- and specialist-based treatment, limiting capacity for prevention and community health services.[43] Payment systems reward procedures and hospital activity rather than proactive management, while data systems and performance metrics prioritize clinical outcomes over population health indicators. Many payers underfund or exclude preventive services from coverage, reinforcing the bias toward treatment and reactive care.[44] This reactive legacy operating model makes it difficult to integrate, fund, and scale prevention and early intervention services.

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[36] Kerri A. Mullen et al., "Effectiveness of a hospital-initiated smoking cessation programme: 2-year health and healthcare outcomes," *Tobacco Control*, 2017, Volume 26.
[37] Gauden Galea et al., "Quick buys for prevention and control of noncommunicable diseases," *Lancet Regional Health – Europe*, 2025 Volume 52.
[38] "Expenditure for selected health care functions by health care providers," Eurostat, accessed November 7, 2025.
[39] Martin De Benito Gellner, "Which countries are spending the most on preventive care?," Healthcare Business International, June 16, 2023.
[40] Mehdi Ammi and Farzaneh Davarzani, "Econometric analysis of the long-run relationship between preventive care spending and mortality: evidence from OECD countries, 1970–2019," *Empirical Economics*, September 2025, Volume 69.
[41] Jaithri Ananthapavan et al., *Economics of prevention: Synthesis of knowledge from the Prevention Centre*, The Australian Prevention Partnership Centre, June 2024.
[42] Eyal Zimlichman et al., "Health care 2030: The coming transformation," *NEJM Catalyst*, 2021, Volume 2, Number 2.
[43] Abigail M. Ross and Lisa de Saxe Zerden, "Prevention, health promotion, and social work: Aligning health and human service systems through a workforce for health," *American Journal of Public Health*, 2020, Volume 110, Number 10.
[44] Susan Levine et al., "Health care industry insights: Why the use of preventive services is still low," *Preventing Chronic Disease*, 2019, Volume 16.

— *Time horizons:* The perception that prevention is primarily a long-term investment conflicts with political and budget cycles.[45] For example, standard ten-year fiscal windows used in countries such as the United States systematically undervalue the full effects of preventive health measures over time,[46] contributing to chronic underinvestment in human capital.[47]

— *Misaligned incentives:* When prevention works, the gains are rarely returned to the provider of those interventions: for example, a community care provider does not see a return from an avoided hospital admission, or share the value of their clients' higher productivity and attainment in the workplace. Even within the health sector, savings may be perceived as lost revenue by some providers. Moreover, for many health system leaders, the challenge of dealing with a growing population of older and sicker people, takes precedence over promoting holistic health over the lifespan. This focus is understandable, yet it is self-perpetuating and unsustainable, and can only be solved by a rebalancing of priorities in favor of more upstream investments.

Path forward

To break the cycle, governments should reframe disease burden as an invisible debt on their national balance sheet: Interest is paid through lower labor force participation, lower productivity, and higher healthcare costs, and keeps compounding year over year. Investing in prevention is therefore a form of fiscal risk reduction, effectively paying down the principal on that debt to lower future economic and fiscal interest payments and stabilize long-term fiscal health.

To operationalize this shift from reactive treatment to proactive care and prevention, governments can take a series of targeted actions that encourage greater measurability, financial visibility, and political durability.

— *Make prevention's fiscal and health value visible:* Governments could treat prevention like any other capital investment—measured, modeled, and managed for return. Integrating prevention as a distinct category in national health accounts, standardized through frameworks such as the OECD System of Health Accounts, can make spending more transparent.[48] In addition to tracking fiscal flows, governments could establish a complementary "national health outcomes account" that links preventive spending to measurable changes in the health of populations, such as DALYs averted or disease incidence reduced, creating a full picture of prevention's fiscal and health returns. Additionally, prevention could be appraised using the same economic tools applied to infrastructure or energy projects, with ministries of finance mandating ROI and cost-effectiveness analyses. Advanced modeling and data analytics, including AI-driven forecasting, can be leveraged to track preventive investments in real time, estimating lives saved, productivity gains, and costs avoided, thus transforming prevention's "invisible" success into clear fiscal and social value.

— *Design a new operating model for prevention:* Innovation in who delivers care, how it is delivered, and where it happens can transform health systems from reactive to proactive models of care. Reimagining service delivery can help shift care from high-acuity, resource-intensive settings toward primary and community-based environments that keep people healthy. Retraining the workforce, as seen in the NHS community health model, empowers multidisciplinary teams to take responsibility for defined

[45] Brianne Schell, "Let's talk money: Barriers and benefits of investment in public health," Network for Public Health Law, November 1, 2022.
[46] Jackson Hammond, "CBO scoring of preventive health measures – important considerations," American Action Forum, May 31, 2023.
[47] *World Bank Blogs*, "Returns to early interventions at sufficient scale are high," blog entry by Sergio Schmukler, Michael Toman, and Adam Wagstaff, April 9, 2020; "Investors shun long-term ESG rewards in quest for short-term gains," EY press release, December 10, 2024.
[48] "A System of Health Accounts guidelines," OECD, March 16, 2017.

populations and deliver low-barrier, prevention-focused care in everyday settings.[49] Expanding the "workforce for health" to include new, prevention-oriented, community-based roles, similar to social workers, can further bridge clinical and social systems, addressing the behavioral and environmental determinants of health.[50] At the same time, empowering individuals to be their own healthcare workers and take greater ownership of their well-being, by managing care at home and staying physically and mentally active, can reduce disease risk and improve long-term outcomes.[51] Additionally, advances in AI can reshape how we approach health screening and management. In Abu Dhabi, for example, the Department of Health's Population Health Intelligence platform aims at using AI-driven analytics to integrate population and individual data, predict health risks, and enable early, personalized interventions, showing how technology can prevent disease before it becomes acute.[52] This approach can also help identify sex-specific care pathways, enabling more targeted interventions and improved outcomes.[53] Together, these strategies redefine the roles, tools, and settings of care, empowering patients to manage their health, embedding preventive services in daily life, and creating a system designed to sustain wellness rather than treat illness.

— *Build financing models for long-term investment:* Because the full benefits of prevention accrue over decades, governments could adopt financing mechanisms that create lasting revenue streams. Thailand's Health Promotion Foundation uses ring-fenced funds provided by health taxes to safeguard prevention from political volatility.[54] The Health Impact Investment Platform, launched by the WHO and multilateral development banks, provides multiyear concessional financing to strengthen primary healthcare and prevention in low- and middle-income countries, creating predictable, long-term funding that supports strategic investment in health system resilience.[55] To complement these mechanisms, governments can also deploy catalytic capital to stimulate private and philanthropic investment for long-term, high-impact initiatives such as digital health and NCD prevention. Global partnerships such as the Global Financing Facility, which has mobilized more than $1.4 billion in private and domestic resources, demonstrate how public or concessional funding can derisk private investment and sustain prevention financing over time.[56]

— *Align incentives for businesses and consumers:* Population sentiment and market incentives are shifting from rewarding poor health to promoting health, as consumers increasingly demand healthier options, overturning the long-held belief that wellness-oriented offerings are less lucrative. Health systems and societies could empower individuals and communities to play an active role in maintaining their own well-being, and businesses have a pivotal role in making healthy living accessible, appealing, and easy. By designing products and experiences that integrate health into everyday life, companies can shift consumer behavior while capturing growing market demand. Growing consumer interest in functional nutrition and digital wellness solutions is driving spending toward nutrient-rich, clean food offerings and platforms such as fitness trackers and mindfulness apps, illustrating how design

[49] "Population health management," National Health Service (NHS) England, updated April 4, 2025.
[50] Abigail M. Ross and Lisa de Saxe Zerden, "Prevention, health promotion, and social work: Aligning health and human service systems through a workforce for health," *American Journal of Public Health*, 2020, Volume 110.
[51] *Heartbeat of health: Reimagining the healthcare workforce of the future*, McKinsey Health Institute, May 14, 2025.
[52] *A new era for digital health: Abu Dhabi's leap to health intelligence*, Abu Dhabi's Department of Health and World Economic Forum, January 2026; "Department of Health – Abu Dhabi unveils world's 1st AI-powered Population Health Intelligence platform at GITEX Global 2025," Abu Dhabi Media Office, October 15, 2025.
[53] *Blueprint to close the women's health gap: How to improve lives and economies for all*, McKinsey Health Institute, January 21, 2025.
[54] Suladda Pongutta et al., "Lessons from the Thai Health Promotion Foundation," *Bulletin of the World Health Organization*, 2019, Volume 97, Number 3.
[55] "WHO and multilateral development banks kick off €1.5 billion primary health financing platform with new funds and launch of first investment plans in 15 countries," WHO press release, September 23, 2024.
[56] "Nineteenth investors group meeting: GFF strategy approach 2026–2030," Global Financing Facility, November 5–6, 2024.

and gamification can make evidence-based, healthier choices the default.[57] To accelerate this shift, governments can help realign markets through evidence-based fiscal and regulatory tools, such as subsidies for healthy foods, front-of-pack labeling, and differential taxes on sugary drinks, that reward health-promoting behavior. When implemented well, these mechanisms are effective at reducing consumption without reducing economic growth or employment.[58] Well-designed regulations can also encourage companies to invest in reformulation and innovation. Strong reporting standards for nutrition and safety, along with standardized health-impact metrics built into credit ratings, create trust and transparency for investors and consumers, further enhancing accountability.

2. Unleashing multisectoral action to drive progress in health and beyond

Investing in the health of populations yields benefits that extend far beyond the health sector. Stronger health enables better educational attainment, greater workforce productivity, and more inclusive economic growth.[59] In turn, progress in these areas reinforces healthier lives, creating a virtuous cycle where multisectoral action amplifies outcomes across society. Unlocking this flywheel effect requires intentional collaboration and shared accountability across all sectors.

Studies show that countries achieve stronger and more sustainable economic growth when their health investments are integrated with investments in the wider determinants of health.[60] For example, school meals and micronutrient programs improve attendance and learning outcomes, while investments in safe water and sanitation deliver high returns by reducing disease and increasing workforce participation.[61] Cleaner air and safer, more active transport systems similarly yield a "triple dividend" of better health, productivity, and environmental gains.

Ultimately, healthier populations are not just the outcome of progress; they are the engine that sustains it. Why, then, is cross-sector execution still rare?

— *Fragmented incentives:* Ministries often pursue sector-specific goals, limiting collaboration on shared outcomes.[62]

— *Siloed budgets and accountability:* Funding streams and performance metrics are structured within institutional boundaries, making joint investments difficult.[63]

— *Limited measurement of cross-sector returns:* The broader benefits of health investments for education, labor, and the economy are often not systematically tracked, leaving finance and planning ministries unable to see the full value of prevention and health promotion.[64]

[57] "The $2 trillion global wellness market gets a millennial and Gen Z glow-up," McKinsey, May 29, 2025.
[58] Guillermo R. Paraje et al., "Taxation of tobacco, alcohol, and sugar-sweetened beverages: Reviewing the evidence and dispelling the myths," *BMJ Global Health*, 2023, Volume 8, Number 8.
[59] Yujie Cui, Gordon Liu, and Yao Yao, "The impact of health on growth: From the perspective of economic structure evolution," *Health Economics Review*, 2025, Volume 15, Number 57.
[60] "Intersectorality," European Observatory on Health Systems and Policies, accessed November 2025.
[61] *The state of school feeding worldwide 2024*, World Food Programme, 2025; "Mission-critical: Invest in water, sanitation and hygiene for a healthy and green economic recovery," WaterAid, 2020.
[62] *Working together for equity and healthier populations: Sustainable multisectoral collaboration based on health in all policies approaches*, WHO, August 31, 2023.
[63] Robin S. Lau et al., "Siloed mentality, health system suboptimization and the healthcare symphony: A Canadian perspective," *Health Research Policy and Systems*, 2024, Volume 22, Number 87.
[64] Mariana Dyakova et al., *Investment for health and well-being: A review of the social return on investment from public health policies to support implementing the Sustainable Development Goals by building on health*, WHO Regional Office for Europe, 2017.

Path forward

The remedy is to reposition health as a driver of national development and institutionalize cooperation, financing mechanisms, and metrics to align incentives across sectors by doing the following:

— *Creating cross-departmental coordination and financing mechanisms:* One effective strategy is to establish interministerial prevention or health promotion funds that pool resources from health, education, transport, and environment budgets. Some countries, such as Zambia, have already included such pooled funding in their national strategy.[65] This enables cofinancing of interventions that deliver benefits across multiple domains. Governments can go further by adopting outcome-based cofinancing models, in which each ministry contributes based on measurable results such as improved school attendance, reduced absenteeism, or lower pollution levels, ensuring every sector sees tangible ROI. Joint pilot programs can demonstrate how collaboration pays off in practice. For example, investments in physical infrastructure (such as roads, schools, water systems) deliver greater returns when populations are healthier, underscoring the value of coordinated investment strategies.[66] Similarly, blended development funds, combining public, donor, and private capital, can finance infrastructure projects that yield both health and economic dividends, such as clean water systems, sanitation, and active-mobility networks that improve physical activity while reducing emissions.

— *Mobilizing innovative finance and private partnerships to shape healthier markets:* Health-positive innovation can be accelerated through public–private partnerships (PPPs) that can co-design healthier products, digital wellness tools, responsible marketing, and healthier employee environments (see sidebar "The role of employers in advancing health and productivity").[67] Partnerships with tech companies can further amplify prevention and wellness through data-driven nudges,[68] credible information campaigns, and healthier digital environments,[69] while blended-finance models and catalytic capital derisk private investment in reformulation, digital health, and supply chain modernization.[70] Impact-linked instruments, such as outcome bonds or results-based tax incentives, reward measurable health improvements, and debt-for-health swaps can free new resources for sustainable production in emerging markets. For example, the Cameroon Cataract Development Impact Bond (2018–23) mobilized $2 million in up-front capital to expand access to cataract surgery and repaid investors in full with performance returns, proving that health-focused impact investments can deliver both measurable outcomes and financial returns.[71]

— *Embedding health into national development planning:* Health impact assessments can be mandated for major economic, infrastructure, and environmental policies to ensure they contribute positively to population well-being. Over the long term, health could be made a core pillar of national performance frameworks, explicitly linked to economic competitiveness and human capital development. Countries that have embedded health in multisector long-term development strategies, such as Chile and Thailand,[72] show how universal coverage, social protection, and education can reinforce one another when designed as a system rather than in silos.[73]

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[65] *National Health Strategic Plan 2022–2026: Towards attainment of quality universal health coverage through decentralisation*, Republic of Zambia Ministry of Health, 2023; for more, see the Health Promotion Fund Resource Hub.
[66] Charles Kenny and George Yang, "Should infrastructure investors care about human capital?," Center for Global Development working paper, number 624, October 2022.
[67] Sharon McDonnell et al., "The private partners of public health: Public-private alliances for public good," *Preventing Chronic Disease*, 2009, Volume 6, Number 2.
[68] Lilja Gudrun Johannsdottir et al., "Digital nudging in digital health technologies: a systematic review," CoLab, June 27, 2025.
[69] Robert S. Gold et al., "Digital health communication common agenda 2.0: An updated consensus for the public and private sectors to advance public health," *Health Education & Behavior*, December 2019, Volume 46.
[70] "Insights & Impact: Blended finance," *Health Finance Institute*, 2025.
[71] "Case studies: Cameroon Cataract Bond," Government Outcomes Lab, February 22, 2022.
[72] Patricia Frenz et al., "Achieving effective universal health coverage with equity: evidence from Chile," *Health Policy and Planning*, September 2014, Volume 29, Number 6; Kanitsorn Sumriddetchkajorn et al., "Universal health coverage and primary care, Thailand," *Bulletin of the World Health Organization*, 2019, Volume 97.
[73] *Health at a glance: Europe 2022: State of health in the EU cycle*, OECD, 2022.

The role of employers in advancing health and productivity

The workplace is an increasingly influential setting for improving health and well-being, reaching individuals where they spend a significant portion of their day. Yet, a McKinsey Health Institute (MHI) global survey found that only 57 percent of employees reported good holistic health. With more than 3.5 billion individuals participating in the global workforce, employers play a critical role in shaping health outcomes.[1]

As care delivery evolves beyond traditional clinical settings, employers are helping extend health promotion and prevention through initiatives such as wellness programs, on-site screenings, and mental health support. Evidence from MHI indicates that many effective workplace health interventions are relatively easy to implement, particularly those integrated into daily work routines and existing organizational structures. Partnerships with healthcare providers, insurers, and community organizations can further help employers expand access to preventive services and complement public health systems.

Employers can promote well-being by shaping both the physical and cultural work environment. Measures such as nutritious food options,[2] support for active commuting,[3] and safe, ergonomic environments,[4] combined with supportive leadership, flexible schedules, and attention to work–life balance,[5] help reduce stress and encourage healthier behaviors. Policies such as smoke-free campuses[6] and fitness benefits[7] reinforce these norms and embed well-being into everyday work life.

Employers can also directly deliver preventive interventions such as routine health checks,[8] vaccinations,[9] and digital wellness tools[10] that encourage early identification and proactive management of health risks. These approaches improve individual outcomes while enhancing organizational resilience through higher employee engagement, productivity, and fewer preventable absences, underscoring the need for sustained employer action to realize these benefits at scale.[11]

[1] Barbara Jeffery, Brooke Weddle, Jacqueline Brassey, and Shail Thaker, *Thriving workplaces: How employers can improve productivity and change lives*, McKinsey Health Institute, January 16, 2025.
[2] Ashika Naicker et al., "Workplace cafeteria and other multicomponent interventions to promote healthy eating among adults: A systematic review," *Preventive Medicine Reports*, 2021, Volume 22.
[3] Nadine C. Page and Viktor O. Nilsson, "Active commuting: workplace health promotion for improved employee well-being and organizational behavior," *Frontiers in Psychology*, 2017, Volume 7.
[4] Manila Duhan et al., "The impact of ergonomics on occupational performance and well-being: A comprehensive review," *International Journal for Multidisciplinary Research*, 2025, Volume 7, Number 2.
[5] Hamidah Nabawanuka and Emre Burak Ekmekcioglu, "Millennials in the workplace: Perceived supervisor support, work–life balance and employee well-being," *Industrial and Commercial Training*, 2021, Volume 54, Number 1.
[6] *The effect of smoke-free policies on workers' health: The need for smoke-free laws*, American Cancer Society Cancer Action Network, July 9, 2024.
[7] Maria Marín-Farrona et al., "Effectiveness of worksite wellness programs based on physical activity to improve workers' health and productivity: A systematic review," *Systematic Reviews*, 2023, Volume 12, Number 1.
[8] Saifullah Hakro and Li Jinshan, "Workplace employees' annual physical check-up and during hire on-the-job to increase health-care awareness perception for disease-risk prevention: A work-for-policy-implementable option globally," *Safety and Health at Work*, 2019, Volume 10, Number 2.
[9] Frederik Verelst et al., "Workplace influenza vaccination to reduce employee absenteeism: An economic analysis from the employers' perspective," *Vaccine*, 2021, Volume 39, Number 14.
[10] Saeed Amirabdolahian, Guy Paré, and Stefan Tams, "Digital wellness programs in the workplace: Meta-review," *Journal of Medical Internet Research*, 2025, Volume 27.
[11] Lucia Tarro et al., "Effectiveness of workplace interventions for improving absenteeism, productivity, and work ability of employees: A systematic review and meta-analysis of randomized controlled trials," *International Journal of Environmental Research and Public Health*, 2020, Volume 17, Number 6.

— *Building shared metrics and accountability systems:* Governments could develop indicators that capture how cross-sector investments improve both health and non-health-related outcomes, such as reduced sick days, improved school attendance, and higher labor productivity. In Finland, for example, the government's "Health in All Policies" initiative uses such shared indicators to track health and socioeconomic outcomes across ministries.[74] These metrics are reported through Finland's National Health and Well-being indicator portal (Sotkanet) and jointly reviewed by ministries and municipalities, ensuring the fiscal and social benefits of prevention are visible across government.[75] Such transparency reinforces political commitment and helps make the fiscal benefits of prevention visible to ministries of finance and planning.

[74] "Management of health and wellbeing promotion: Health in All Policies," Finish Institute for Health and Welfare, July 12, 2023.
[75] "National Health Index," Finnish Institute for Health and Welfare, September 6, 2025.

3. Boosting health spending efficiency to maximize outcomes

As health spending reaches historically high levels, the dialogue is often framed as a trade-off between controlling costs and continuing to invest in health.[76] In practice, these objectives must be reconciled. By generating greater health impact from existing resources through choosing the right portfolio of high-return interventions, optimizing care delivery, and reducing waste, health systems can get the most health per dollar. This approach creates the fiscal space needed to invest in areas that reduce avoidable demand and bend the cost curve over time. In this sense, managing costs and investing in health are not competing priorities, but mutually reinforcing elements of the same strategy. Cross-country analysis by the International Monetary Fund has found sizable, actionable differences in health-spending efficiency, suggesting there is an opportunity to deliver better overall health outcomes through more effective use of current resources and spending.[77]

Improving the efficiency of healthcare services involves addressing significant barriers, such as the following:

— *Institutional resistance and transition costs:* An honest conversation about whether the highest health ROI interventions are truly being resourced and incentivized will often challenge entrenched interests and established funding structures. Additionally, current financing structures frequently reward activity over value, paying for the volume of treatment rather than the outcomes of treatment.[78] At the same time, transitions often require significant up-front investment in infrastructure, workforce retraining, and temporary parallel operations, costs that can deter change even when long-term savings are clear. Compounding this challenge, health systems sometimes invest in infrastructure or technology solutions that add cost and complexity without improving outcomes, mistaking expansion or digitalization for transformation.

— *Systemic complexity and governance fragmentation:* Implementing efficiency reforms such as centralized procurement, integrated logistics, or digital health systems demands coordination and performance-based financing. Misaligned incentives, siloed budgets, and fragmented decision-making structures make it difficult to reallocate funds toward higher-value uses.[79] Without clear accountability and coordination, even well-designed efficiency initiatives can stall.

— *Technology limitations and low analytical trust:* Many health systems lack the data infrastructure and analytical capacity needed to guide reallocation based on performance in real time.[80] Complex data protection and confidentiality requirements and a lack of common data standards limit interoperability and data sharing. Moreover, where AI or predictive analytics are introduced, weak transparency and governance can undermine trust, limiting their adoption and impact.

Path forward

Governments have a critical role in supporting healthcare providers across all sectors—public and private—to improve productivity. The goal is not to cut spending but to ensure resources are directed to the highest-return interventions and support objectives such as expanding access, propelling innovation, and strengthening equity. Advances in digital infrastructure, data analytics, and AI are making long-standing

[76] *Financing Global Health: Explore patterns of global health financing*, Institute for Health Metrics and Evaluation, 2025.
[77] Mercedes Garcia-Escribano, Pedro Juarros, and Tewodaj Mogues, *Patterns and drivers of health spending efficiency*, International Monetary Fund working paper, number 2022/048, March 2022.
[78] Luca Lindner and Luca Lorenzoni, *Innovative providers' payment models for promoting value-based health systems*, OECD working paper number 154, April 2023.
[79] Agnes Gatome-Munyua et al., "Reducing fragmentation of primary healthcare financing for more equitable, people-centred primary healthcare," *BMJ Global Health*, 2025, Volume 10, Number 1.
[80] *SCORE for health data technical package: Global report on health data systems and capacity*, WHO, 2020.

efficiency challenges increasingly feasible to address. These technologies, combined with redesigned implementation pathways, are enabling smarter operations and real-time resource allocation, turning efficiency reform into a practical, achievable agenda.

— *Reorient care toward high-value models:* Governments can reorient service delivery toward primary and community-based care through their funding choices. In Kenya, for example, investments in primary healthcare yielded up to $16 in health system savings per dollar invested.[81] Public and private payers can use claims data (collected in some form by health systems everywhere) to identify opportunities for more proactive and lower-cost care. For example, in the United States and the United Kingdom, AI-driven programs are starting to analyze real-world healthcare data coupled with redesigned care models. They can generate meaningful outcomes when applied to specific cohorts, such as seniors with multiple co-morbidities. When fully deployed, AI-enabled patient-centric models of care have the potential to reduce admissions by more than 50 percent.[82] By prioritizing evidence-based investments and scaling solutions that reduce costs and improve outcomes, governments can ensure that every dollar spent drives measurable health value.

— *Create incentives for providers to modernize systems and operations:* To improve efficiency and accountability, governments can align financial incentives to reward providers for adopting smarter, technology-enabled operations, for example, using pricing mechanisms that reimburse providers not on the basis of average historic costs (as many systems do today) but on the basis of efficient delivery of best-practice care in the most appropriate, and least resource-intensive, setting.[83] For example, governments could create value-based payment models that align financial incentives with cost-effectiveness. In the United States, Accountable Care Organizations (ACOs) link provider payments to health outcomes. Under this approach, groups of healthcare providers, such as hospitals, physicians, and community clinics, are held accountable for managing the total cost of care for a defined patient population against a per-member-per-month spending benchmark set by public payers such as the Centers for Medicare & Medicaid Services. If the ACO delivers high-quality care and keeps total spending below an agreed benchmark, the participating providers share in the savings. However, if costs exceed that benchmark, they may share in the losses, creating a two-way incentive to limit costs and optimize outcomes.[84] These types of incentives can encourage providers to adopt more efficient care delivery practices, including improved care coordination, reduced low-value utilization, and strengthened chronic-disease management.

— *Institutionalize tech-enabled efficiency and reinvestment for sustainable impact:* Efficiency reforms are most effective when anchored in strong data systems and clear governance. Integrated health-data platforms and real-time analytics enable governments and providers to identify inefficiencies and improve outcomes while reducing costs. Reforms such as pooled purchasing, centralized tendering, and integrated logistics consistently deliver savings and improve access to essential medicines. Shifting to digital payments and performance-based financing enhances transparency and ensures funds reach frontline services quickly.[85] Additionally, AI-driven supply chains now forecast demand, automate replenishment, and optimize distribution, reducing delays, stockouts, and overordering.[86]

[81] Daniel Mwai et al., "Investment case for primary health care in low and middleincome countries: A case study of Kenya," *PLoS One*, 2023, Volume 18, Number 3.
[82] John Edwards, "The new cost engine: How AI and automation are reshaping health care economics," Medical Economics, August 14, 2025.
[83] 2025/26 NHS Payment Scheme, UK National Health Service (NHS), April 4, 2025.
[84] Joe Albanese, "Two paths for Medicare's future: Medicare Advantage and accountable care organizations," Paragon Health Institute, January 15, 2025.
[85] "Health Financing and Economics: Digital technologies in health financing," WHO, accessed January 2026.
[86] Pradeep Verma, "Transforming supply chains through AI: Demand forecasting, inventory management, and dynamic optimization," *Integrated Journal of Science and Technology*, September 2024.

Evidence also shows that AI-enabled triage systems can cut time to treatment by up to 20 percent.[87] These efficiency gains free up valuable resources, allowing cost savings to be reinvested in health. To ensure the benefits of more efficient care delivery are directed toward transforming our health systems for better health and prosperity for all, governments could establish data-driven reinvestment systems to channel savings into priority areas such as prevention and innovation, using efficiency-to-impact pipelines to ensure funds are not lost to general expenditure. For example, in 2024, Ireland's Department of Health launched a national Productivity and Savings Taskforce that identified more than €600 million in health system efficiency savings, with plans to reinvest these funds to improve frontline services and patient outcomes.[88] Innovation can also change what it looks like to spend on health, shifting systems from labor-intensive delivery models to tech-enabled prevention and primary care. But innovation does not automatically create value: Evidence in areas such as oncology shows that some new, high-cost therapies have delivered only modest average gains in survival or rely on surrogate endpoints, underscoring the importance of directing adoption and reinvestment toward innovations that measurably slow disease progression or improve outcomes per dollar.[89]

In the next quarter century, investing in health represents a critical and strategic opportunity to transform both global health and economic outcomes. Scaling access to known, cost-effective interventions could prevent millions of premature deaths, extend healthy life expectancy, and generate trillions of dollars in economic gains annually by 2050, with a fourfold estimated global ROI.

Amid demographic shifts, increasing chronic disease prevalence, and tightening fiscal constraints, postponing health investments threatens to undo decades of progress. Now is the time for decisive action to promote healthier populations, enhance workforce productivity, and reinforce economic resilience.

Yet, despite compelling evidence, health remains underprioritized in budgetary and policy frameworks worldwide. What will it take to make smart investments in health and seize our economic future?

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[87] Adebayo DeCosta et al., "AI-driven triage in emergency departments: A review of benefits, challenges, and future directions," *Lancet Digital Health*, 2025, Volume 197.
[88] "Minister for Health Jennifer Carroll MacNeill updates cabinet on details of the Productivity and Savings Action Plan for 2025," Ireland Department of Health, April 1, 2025.
[89] Huseyin Naci et al., "Overall survival benefits of cancer drugs initially approved by the US Food and Drug Administration on the basis of immature survival data: a retrospective analysis," *Lancet Oncology*, June 2024, Volume 25, Number 6.

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