Industry Insights with KPMG Economics

Healthcare and Life Sciences edition

Hello. Welcome to Industry Insights with KPMG Economics – Healthcare and Life Sciences edition. Industry Insights with KPMG Economics is series featuring chief economist Diane Swonk, who will be exchanging ideas with the national sector leaders here at KPMG.

In this edition, Diane and sector head Ash Shehata discuss the change taking place in the Healthcare sector from the impact of technology and innovation, labor shortages and inpatient outcomes. So, let's begin….

Diane Swonk: Hi Ash It's great to be here with you. You know we've been talking a lot about everything. How broad the healthcare space is and life sciences space that you cover! Do you really give me a sort of lay of the land, starting out with the Payer provider end of things in terms of. I know how diverse spaces. But what are the issues you're seeing on the ground in terms of what they're dealing with right now?

Ash Shehata: Well, thanks Diane, it's pleasure to be with you today, and, as you know, the organizations and across health care, and also the payer space, have been very, very active. Obviously throughout the pandemic. But more importantly, even now. There's been a lot of activity, as you know, around provider consolidation. There's been continued interest in acquiring provider practices. Private equity, of course, was very, very busy up until the beginning of this year. So clearly. We're seeing that pause. But I think there's just you know the main theme right now is cost, cost, costs, labor, labor, labor. And you know, Diane. We've met with the CFOs across the industry. Everybody's looking for every possible solution in that area.

Diane Swonk: You know, on the cost side. It's one thing that struck me is before we hit the pandemic, I know the average ages of nurses were about 50, which was higher than the average age of the overall population, and we saw that people call it the Great Resignation, which is my least favorite word, because it really didn't describe what was happening. But clearly people got burned out in the health, care industry, and we saw an increase in both retirements, but also a lack of supply of people coming into the space. And we're just seeing now in terms of hiring some catch up to what was an extraordinary shortfall, especially in the week of the initial pandemic and everything from nursing home care. You know, in the in the really the here, the health care providers that we're doing the most hands on in industry.

And I think you know, one of the things that I keep worried about and thinking about is as we're seeing the costs come in, and there's still shortages of you know, really patient care, and stepping up. We know it from our own queues. I know from getting into the doctor's office. It's hard to do right now because there's slammed. They're really backlogged [and] the cost pressures are building. This is something the Fed is also concerned about. But walk me through. You talked about the earlier M&A activity that was in the industry, the consolidation. What do you see going forward in terms of the you know, especially the rural versus urban hospital space. The profit versus nonprofit.

I'm really worried from an inequity standpoint as well. What this means for the overall labor force and the help of the labor force more broadly. When you hit health care you affect the overall economy.

Ash Shehata: I think, Diane, you're spot on, and I think those concerns are exactly where you know. The heads of the CFOs and the CEOs and Boards are right now, you know, as we move to this kind of massive consolidation and even compression of resources. Organizations have had to really do 3 things. Number One obviously reduce costs across the board which they've been busy at doing. Number 2 is they've been consolidating resources for greater efficiency, which includes, you know, potentially impacting the viability of the rural health care community. And then the third one we've been, you know, kind of experiencing this phase of what it called hyper automation. People are looking for every possible way to go beyond the traditional electronic health record modernization and moving to. You know, economies and capabilities that will help us, you know, permanently reduce costs, because I think we all agree right now that you know, with, with some of the big wage increases. We've seen the health care bargaining settlements on both east coast, west coast, and the central region. We likely will see continuity of high wage pressure for years to come.

Diane Swonk: Yeah, the kind of wage pressures you're talking about are pretty stunning as well, and their ones that certainly catch the attention of the Federal Reserve. Not that we don't want people to earn higher wages, we want them to do it in a productive way. They can sustain the wage gains without inflation, eroding it in a big part of inflation. You and I will go back enough to remember a big part of inflation in the 90s. Was the health care sector, and you know I am worried about that becoming a push on inflation going forward. It is already in some of the health care measures. But before we get to that, you know this issue of AI and the incredible role it can play.

But also, how does it delineate? Because we've got, you know, sort of this concept of work from anywhere? Well, that doesn't really work. If you don't have access to health care in rural areas nor broadband, which is really critical to many of the sort of labor-saving technologies that can also enhance the quality of the care we get and really bridge skills gaps which, from an economic standpoint, the tire meets the road in terms of productivity, growth and really delivering to the bottom line. When you marry that technology with people, it's not just replacing labor with capital which I think so many people see out there can you get into what kinds of trade-offs are firms thinking about when they're looking at that kind of stuff.

Ash Shehata: I think it's spot on. You know, the big issue with health care, as we know, isn't necessarily just the efficiency factor. It's we've been running several years of really labor gaps, and not only on the clinical workforce it's also the staff support, and I think the idea that we can somehow, you know, move that workforce to the home doesn't really kind of pervasively impact the health care delivery system obviously back-office functions clearly. There's you know, impact there and opportunity. But on the clinical roles it really is going to be about getting efficiency to help kind of close the gap of that labor gap. And it's one that we've been, you know, writing about. We've been warning about. We've been studying it globally even. And I think what ended up happening with a pandemic. It's kind of, you know, brought all of our fears to fruition. And now we kind of have to settle in and work through it on top of. You know, a very complex economic environment. So, the navigation of this is going to be very skillful. But I do think you know, leaders are definitely changing the way they're thinking about these approaches, and I think the more important part around health care is, can we even learn from this consumer-centric environment. You've always taught us a lot about looking at the different signals of the economy. And the consumer signals are definitely starting to permeate health care.

Diane Swonk: In terms of how you've got this squeeze on margins, and you've got them wanting to obviously to increase the quality of care. They also want to reduce costs. They're dealing with the labor situation that is not going to go away, even if we have a recession. This is not a sector that, except for the pandemic, ironically enough, hit the health care sector. It was one first time we ever saw the health care sector hit, and people didn't understand why that happened, and I always try to remind people that people stop going to their doctors in February of 2020, and we want 1.7 million jobs before we ever entered a recession, and a lot of it was in health care. People didn't want to go their dentist, for obvious reasons, because of their fear of contagion. So now we are in the place where we're back, trying to catch up to what was already a very tight labor market,

shortages of nurses, shortages all the way down and up and down the skills. Strata, what are your clients doing right now in terms of what can they afford to adapt? And where do they want to place their bets on these new technologies?

Ash Shehata: I think it's a great question. I think we're seeing kind of 3 areas of innovation. One is obviously around the delivery system. So, being able to kind of refocus, not only within the inpatient hospital focus on outpatient facilities, and even looking at more and new and varied services to the home. So, I think that's been really important to kind of look at, varying the type of an intensity of services across the continue. The second area is also getting into some of the newer areas and using newer technologies to enter them at scale things like mental health services. Also, you know, long term care has become a big, popular kind of post pandemic boom, both of private equity and being able to use primary care to help improve the efficiency of the discharge process is really, really important. And I think the third one which we're likely going to see is, you know, a lot more kind of creative financing, you know, as we look at modernizing our buildings, our infrastructure, you know it does. It needs to be kind of all in in one container right now. Does the health system have to shoulder it and burden it.

Ash Shehata: And I think you're going to start to see new entrance into the space. So, you know, even though we have a lot of head winds in front of us. People are coming to the table. Very creative solutions. Technology partners are coming to the table with infrastructure and new innovations. And I think the willingness for the traditional health care ecosystem to go beyond its 4 walls to seek these solutions is really now born out of necessity.

Diane Swonk: You know it's interesting. You bring it up, and we'll get into some of the other areas. I know you're covering but one of the things that struck me. I was talking to someone recently who was talking about. Well, I'm thinking about retire, and one of the things that was Number one in their list. Am I going to be close to a good health care provider, and all the services that requires because they were looking at more rural areas, and that was one of the things that they saw as a negative, and they were worried about that sort of access. And when you're talking about, you know, although you can't do obviously in person, health care. You know, from home the fact that we've got a lot of employers looking out there.

This is another issue they have to consider is, how much is it going to cost for them to ensure their workers, but also can their workers ensure that they get access to health care in all the places that they're located, and that's something that I think about in terms of the health of the economy and health, the labor market as well. I'm going to go a little further with you now in terms of you know your work in life sciences, because you know that's what's sort of the magic frontier in some ways; and I get excited about it as a cancer survivor myself, having 11 surgeries during the pandemic. It really is just amazing to me to see what's happening out there, but also, it's not free, and you know what is the momentum? And you know this is an area where start-ups in the overall economy have played an extraordinary role in supporting and making for the resilience of employment. And now we're seeing some changes in that funding and that could diminish the role that they play. And it's something that I'm thinking about quite a bit. I'm excited about the dynamism we've seen, but I'd like to get your perspective on what you're seeing in life sciences, and I know you cover a lot of different sectors in that. But you know, starting out in the overall life sciences, and we'll drill down a little more.

A**sh Shehata:** Yeah, I know I'll focus kind of on those main themes. But you know, overall, we are still seeing an amazing kind of push forward in the biotech space, you know, with the dawn of kind of precision medicine, and you know, you know, being, you know, very, very close to cancer care. Obviously, you know, oncology's a major ability right now to really go after some of these you know very long, and you know very complex diseases. I do think we're also seeing kind of a nice push, post pandemic with the use of technologies like Messenger RNA. We've seen some very great advances where they're taking those combined therapies with more traditional drugs and finding some very, very innovative impacts.

So, I think, with all that complication and difficulty, and innovation also comes kind of the complexity of you know this whole biotech model. It's still very much academic based in some of the bigger kind of life sciences organizations and I think, in order for this to unleash its capability across the health care system, I always kind of call it, we have to rewire the system. And the system has to work very collaboratively with labs, pharmacies, and distribution networks. Insurance has to look at these solutions much differently than it does. And

then you brought up the issue of health equity. We have to really start to take on the topic of health equity much more broadly. And I think life science is gearing up for that as well as we get into more of the transparency initiative. So, what it comes with is great opportunity. Also, we're seeing much more complexity than we have with traditional drug launches.

Diane Swonk: So, you know it's interesting. You bring this up because it's something that you'd also touched on when we talked before, and that is the issue of private sector getting very involved in some of the solutions that are already out there, and wanting to brand it, and wanting to be a part of it, which would be one way of spreading it more to the masses. What do you see going on with that? I think you'd mentioned one with, you know diabetes and dealing with diabetes and the advances that we're making there. And what's happening? Talk about that a little bit in terms of how that's shifting the entire, or sort of rewiring it as you put it, the whole network, because I think back on, you know, when I see these things on 60 Minutes and when I watch what's going on in the healthcare space, and even talking to my doctors. I'm amazed at what they're doing at the big hospitals and at the big research clinics, and even MIT like you said in academics with AI, and they're sort of monitoring, you know the ability to monitor a preemie baby and not touch it until it needs to be intervened upon, because that can compromise their lifespan, that you can improve these qualities. But it being done in a very academic sort of not necessarily with the same attention to profits and costs as you would have elsewhere in the economy. How do you see that shifting right now?

Ash Shehata: I think it's a great one. And just in the diabetes space, you know there's some tremendous blockbuster drugs right now that are, you know, making their way through the system. And we've obviously learned that those drugs now also have a very, you know, amazing reciprocal of that which is amazing weight, loss. They're kind of sweeping the nation right now, and people are kind of going through quite a bit around what the cost of it is what's the best delivery model? Can we make it available? There's obviously quite a bit of supply chain shortage, just because we you get these kind of dramatic, market shaping drugs. We also start to see supply shortages. But what is interesting is when you think about the future. You know, when you think about organizations that, for example, have been in weight loss, and diet for years being able to combine the ability to deliver that, you know amazing weight loss therapy, reduce the effect of diabetes, and maybe even do it through telemedicine and mail order pharmacy, you know. That's when we're starting to see that kind of combination of capabilities, I think quickly, we're going to get into a reimbursement model that will, you know, start to support this kind of innovation as well. So, I think you know we have a lot of questions about it, and I always bring this one forward, and there's going to be similar examples with Alzheimer's drug discovery and others. But these are the things that will start to move our whole system forward if we can start to create that chasm between public/private partnerships, and then the broader distribution of our healthcare economy.

Diane Swonk: You know that brings up an issue that I think you know, often gets lost in translation that I'm sure you're aware of. And you and you have to deal with, too, is, as we start to think of these bigger solutions that are national based solutions. Right?

There's a lot of individual regulations at the state and local level that we have to deal with, even with nurse practitioners. I mean it's, you know, gotten so that each State has their own sort of verification, and the problem gets to be, how do you deal with? During the pandemic? There was mental health allowed across state borders, for instance, using zoom and teams and things like that, and the ways that we could be much more efficient, and they had to do a lot of things open the door to more of a national platform or more national standards. But where are we in? For as far as the state side of individual, we're seeing a lot of very different views both in political arena, but also, you know, being able to get these things for firms to really want to join in and make it a private partnership. You don't want individual State regulations at every direct individual state. Right?

Ash Shehata: Exactly. Well, and your point is so well taken there's quite a bit of difference, even the way we cover some of the health benefits. So, Medicaid expansion alone, you know, has, you know, massive pervasive effects around coverage around the ability and eligibility factors. And then, more importantly, how hospitals and health systems get reimbursed for that population. So, you know, we are still seeing quite a bit of variability. There's almost a dozen states or so

that haven't kind of expanded Medicaid to the degree that others have. So that's one area that we're still seeing movement. The other area is also just your point of kind of regulatory certification environment you know. There's still quite a bit of shortage of these professionals, and the way. The State bodies also govern and manage the input of those eligible recipients is really, really important. We are seeing some great creativity. But again, there's really not kind of a centralization of effort.

And we do believe that the health care economy is very much driven by the local decisions around staffing and growth, and even, you know, you can look at something like for hospitals the ability of the way they handle certificates of need, and the way they authorize the construction of hospitals and health systems. So, all of these very nuanced solutions continue to drive. You know the ups and downs of the health care economy.

Diane Swonk: Well, on that note I think I have to let us stop and be on an optimistic note for a change. I know you know there is a lot of people who talk about dismal economics and the dismal science, and being able to talk to you, makes it a much less dismal thing to do. So that's a good thing. But you've actually given me some hope here. So, Thank you Ash. I really appreciate your time.

Ash Shehata: Well, thank you Diane.

Outro: You just heard KPMG's Healthcare and Life Sciences sector leader Ash Shehata and Chief Economist Diane Swonk. Subscribe to hear Diane's conversations with our other sector leaders from Healthcare and Life Sciences, Technology, and Consumer and Retail.

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