Thirty years ago, Frederik Pohl’s prophetic science-fiction novel *Gateway* described a future where the ability to afford full medical coverage separated society’s “haves” from its “have nots.” Today, fundamental forces are driving the healthcare industry ever closer in this direction, making large-scale change inevitable. With healthcare spending topping $4.2 trillion, governments and industries across the globe want to ensure that Pohl’s dystopian vision remains the stuff of science fiction.

Global forces will reshape the way every country delivers healthcare during the next 15 years, challenging the social contract between governments and citizens and toppling many deeply held beliefs concerning the role of the state in providing healthcare. The impact on the rest of the health ecosystem will be equally profound, disrupting worldwide pricing, market access and innovation models. In this paper, we describe these global trends, outline the emergence of a common healthcare delivery model and explore the implications for both governments and healthcare suppliers, with a focus on the pharmaceutical industry.

The Impact of Three Global Trends

Three global forces will redefine the healthcare landscape, in all likelihood shutting the door on traditional incremental adjustments and opening the way for seismic change. To understand the common healthcare model that is likely to result, let us examine each of these global forces in turn.

The U.S. model’s failing health. In a sense, Frederik Pohl’s future has already come to pass. The global “haves”—the top 20 healthcare-consuming countries, with 16 percent of the population—spend nearly 90 percent of the total $4.2 trillion. The United States alone, with 5 percent of the population, accounts for more than 45 percent. The “have nots”—the remaining 84 percent of the planet’s inhabitants—spend 11 percent of the total, but suffer from nearly 95 percent of the diseases.

The United States dominates global healthcare spending, and its system has a huge influence on the global healthcare industry. But spending doesn’t necessarily guarantee results, and the U.S. healthcare system increasingly underperforms those of other developed countries. In 1998, for example, the United States ranked 15th out of 19 countries in amenable mortality, meaning deaths that could have been prevented by appropriate healthcare. By 2003, the United States had fallen to 19th place despite boosting spending more than
its peers. Whether the issue is infant mortality, life expectancy or some other key indicator, the U.S. record remains depressingly consistent. As the Commonwealth Fund notes, “Comparative analyses consistently show the United States underperforms relative to other countries on most dimensions of performance.”

The U.S. system also features inequalities that other developed countries would not accept. The United States is one of only three Organization for Economic Co-operation and Development countries that does not provide universal health insurance (the others are Turkey and Mexico). Roughly 18 percent of the population under the age of 65, including disproportionate numbers of minorities and children, goes uninsured, and thus suffers from poor access to basic healthcare. And while this number continues to rise—up 11 percent between 2001 and 2004—the quality of care is declining, as spending per uninsured patient

Figure 1
Trends in the U.S. healthcare system (public and private)

United Kingdom
Sweden
Norway
Denmark
Japan*
France
Finland
Germany
Italy
Canada
United States

Public spending
Private spending

Source: OECD health data, 2005

*2004 data

fell by 10 percent over the same period.

Both of these issues relate to the United States’ unique reliance on private funding and competition to provide incentives for performance. Public money pays just 45 percent of the U.S. healthcare bill, with insurance and patient out-of-pocket spending covering the rest. In contrast, public spending in other developed countries usually covers 70 to 85 percent of the total cost (see figure 1). However, a system based on private insurance—especially one so expensive—cannot deliver universal access to healthcare. As total healthcare costs are nearly double those in many European countries as a percentage of GDP, and the United States is witnessing an increasing shift in funding toward Medicare and Medicaid, it will soon spend more public money as a percentage of GDP than many European countries spend on universal healthcare provision (see figure 2). However, the way public money is distributed is deeply flawed, since it only pays for emergency care, not primary care or prevention, for the uninsured. As public spending overtakes private spending, the United States will soon have a system funded predominantly by general taxation—though not a very effective one.

The U.S. system relies on competition to control costs, but the power of competition tends to be limited in a system where the laws of supply and demand do not really apply. In his book

**Figure 2**
Projected spending on U.S. healthcare

![Figure 2: Projected spending on U.S. healthcare](image)


*Actual percentages*
Healthcare systems around the world have evolved more by chance than design. Although each system contains unique features, all have similar elements. The figure describes the five predominant types of healthcare systems.

Developed and developing nations clearly face different healthcare challenges. Developing countries must eradicate communicable diseases and reduce mortality rates for mothers and children. Developed nations need to manage consumer expectations regarding healthcare availability and deal with the diseases of aging populations. For developed countries, the critical issue centers on the affordability gap, since virtually every developed country faces a funding crisis—or will, in the next five years. However, there are limits to what governments can realistically do, so most end up trying the same things: reduce demand (by improving public health, providing incentives or acting as a service gatekeeper), improve the efficiency and quality of providers, take a more active role in healthcare delivery (by defining best practices or measuring outcomes) and engage in systematic reforms (by increasing competition among providers).

**Figure**

Five basic types of healthcare systems

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**Free market**  
*(unique to the United States)*
- Maintains safety net through public payment of premiums
- Offers services and insurance through private sector

**Bismarck**  
*(instituted in Germany and France)*
- Provides insurance through competing social funds
- Offers multiple sources of provision

**Hybrid**  
*(instituted in the Netherlands and Japan)*
- Requires private insurance for high earners and social insurance for all others
- Provides services through public or private sector

**Beveridge**  
*(instituted in the United Kingdom, Spain, Italy, Scandinavia and Portugal)*
- Funds system through general taxation
- Provides services through public sector; treatment is free at point of care

**Ex-Semashko**  
*(instituted in Russia and former Eastern Bloc countries)*
- Is decentralizing from Communist model and restructuring either to Beveridge or Bismarck system

**Redefining Healthcare: Creating Value-Based Competition on Results.** Michael Porter describes how competition has failed to deliver results in the United States. Still, Porter probably has more faith in the power of the *right* type of competition and less in the role of government than many policy makers in other countries, which rely less on competition than on regulation and state control.

Clearly, incremental approaches will no longer work. The United States—which has dominated the global health industry for so long—needs a complete overhaul of its healthcare system. But the structure of the industry makes these reforms difficult to achieve and, as a result, the U.S. model will gradually lose influence in the rest of the world.

**The developing world's rising importance.** The second trend concerns the industry's shift in focus toward developing markets, where strong population growth and rising economic power will boost healthcare demand. These markets will produce significant new middle-class consumers (defined as those earning between $8,700 and $71,500) by 2020. China, for example, will have nearly 740 million middle-class consumers by then, growing at a rate of 48 million more each year. Even North Africa will gain nearly a million high-income consumers annually.

The growing ranks of middle-class consumers will expand healthcare spending, which tends to rise faster than a country's overall growth in wealth. Between 2000 and 2015, for example, India is forecast to spend 130 percent more on consumer healthcare services. China will spend nearly 80 percent more, and Thailand over 70 percent more. One early sign of the shift toward developing countries involves pharmaceutical-company research and development (R&D) facilities: From 2001 to 2006, companies opened only a handful of new R&D sites in Europe but closed nearly 20, while in Asia nearly 15 new sites opened, with virtually no closures. Furthermore, companies are increasingly turning from core countries (including Canada, Germany, France, Italy, the United States, Spain and the United Kingdom) to non-core, predominantly developing countries to recruit patients for clinical trials. While this move is partially driven by costs, improving infrastructure and the availability of suitable patients, it also indicates where future markets are headed.

**Ailing European models.** The third trend involves the ailing state of most European-style health systems, including the systems in most developed countries such as Australia, Canada and Japan.

European systems spend on average about 10 percent of their countries’ GDP on healthcare, and costs are rising at an average of 5 percent per year. Left unconstrained, healthcare costs would double in the next 18 years. Policymakers might struggle to identify a specific threshold above which spending cannot rise, but it is clear that many consider their current spending growth unsustainable. For example, a study in the United Kingdom compared likely growth in health spending against “affordable” taxation, predicting the emergence of a funding gap that will grow 1.4 percent per year from 2009.\(^2\)

Whatever the amount, there is a limit to how much money from taxes governments can raise for healthcare. Excessive taxation destroys competitiveness and economic performance, in turn reducing the amount of resources available for healthcare and other services. In Germany, employers sued the government to protest the high social cost of employment, and French national insurers currently operate at a deficit of nearly $10 billion.

What factors are driving up healthcare costs? The most likely explanation involves a toxic combination of demographic changes and the increasing cost of medical technology, plus a shift in the types of diseases suffered by people in rich countries. Due to declining birth rates and longer-living populations, the developed world is aging at an alarming rate. By 2020, much of the “old world” will indeed be old, as more than 20 percent of the population will be over 65 years of age.

Providing for their care will put a severe strain on medical resources, all the more so for the way the systems are funded (see sidebar: Worldwide Healthcare Systems). European systems generally try to achieve universal access and solidarity (where the rich subsidize the poor) by funding healthcare through general taxation or compulsory employer and employee contributions to state insurance. This approach worked well when the current healthcare systems were first designed, for example, in 1883 for the Bismarck system in Germany and 1948 for the Beveridge welfare state in the United Kingdom. In 1950, for example, Germany had seven people of working age for every one retired person, according to the United Nations. By 2000, this ratio was four to one, and by 2020 it will be three to one (see figure 3). A more detailed analysis, taking into account employment, retirement and age trends, indicates that the ratio could plunge to as low as 1.2 to one. Nor will the problem be limited to Europe: By 2050, China will have the same age profile as Europe has today, due largely to its one-child policy and extended life expectancy.

This demographic trend may limit the amount of money the young and healthy will be prepared to pay for the older and the sick. Spending does increase with age, but the most

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significant increase occurs in the three months prior to death—so longevity may delay overall expenditures, but it does not significantly change them.\textsuperscript{4} Many empirical studies have found that aging has not been a significant driver of health spending, and age-related increases may have been swamped by other effects. However, aging to date has been modest compared with what is projected to occur over the next 40 years, so it may become a more significant factor in the future.\textsuperscript{5}

What else is causing these increases? A study of pharmaceutical expenditures in France between 1992 and 2000 found that the vast majority of increases resulted from changes in prescription practices (see figure 4).\textsuperscript{6} While some savings resulted from reductions in illness, these were not enough to counterbalance the extra costs of the prescribed drugs.

In most industries, new technology improves productivity—or at least dramatically increases performance at the same cost. In the past, new technologies helped extend life expectancy while reducing the total cost of healthcare. For example, treating stomach ulcers with H\textsubscript{2} antagonists fundamentally improved health outcomes and the economics of treating the condition. Similarly, the use of facoemulsification to dissolve eye cataracts using ultrasound turned this previously difficult operation into an outpatient procedure. However, incremental improvements in life expectancy come at an increasing cost, as diseases that are simpler to treat, such as

\begin{figure}
\centering
\includegraphics[width=\textwidth]{figure4.png}
\caption{Growth in pharmaceutical spending in France (1992-2000)}
\end{figure}


\textsuperscript{4} Yang et al., Health Expenditures and Proximity to Death, 2003; ENPRI-AGIR and OECD.

\textsuperscript{5} Economic Implications of an Aging Australia, Australian Government Productivity Commission, aggregate studies of age and health expenditures, 12 April 2005.

\textsuperscript{6} Dormont et al., Health Expenditures, Longevity and Growth, 2007.
diarrhea and tuberculosis, give way to incredibly complex diseases such as dementia and cancer (see figure 5). The use of new technology to treat these more complex diseases is actually increasing costs today.

Consider cancer treatment. Medical researchers characterize cancer as a disease of affluence, because people in the developing world often do not live long enough to suffer from it. In the United Kingdom, women aged 50 years or older account for 80 percent of new breast cancer diagnoses, while the average female life-expectancy at birth in Africa is just 53 years. Four out of 10 African countries have a life-expectancy of 50 years or less. Similarly, patients aged 70 and older account for six out of 10 new prostate cancer diagnoses in the United Kingdom. This compares with an average male life expectancy at birth of less than 54 years in Africa. According to the World Health Organization, only eight

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**Figure 5**
Top 10 causes of death in high-, mid- and low-income countries

<table>
<thead>
<tr>
<th>High-income countries</th>
<th>Deaths in millions</th>
<th>Middle-income countries</th>
<th>Deaths in millions</th>
<th>Low-income countries</th>
<th>Deaths in millions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coronary heart disease</td>
<td>1.34</td>
<td>Stroke and other cerebrovascular diseases</td>
<td>3.02</td>
<td>Coronary heart disease</td>
<td>3.10</td>
</tr>
<tr>
<td>Stroke and other cerebrovascular diseases</td>
<td>0.77</td>
<td>Coronary heart disease</td>
<td>2.77</td>
<td>Lower respiratory infections</td>
<td>2.86</td>
</tr>
<tr>
<td>Trachea, bronchus and lung cancers</td>
<td>0.46</td>
<td>Chronic obstructive pulmonary disease</td>
<td>1.57</td>
<td>HIV/AIDS</td>
<td>2.14</td>
</tr>
<tr>
<td>Lower respiratory infections</td>
<td>0.34</td>
<td>Lower respiratory infection</td>
<td>0.69</td>
<td>Perinatal conditions</td>
<td>1.83</td>
</tr>
<tr>
<td>Chronic obstructive pulmonary disease</td>
<td>0.30</td>
<td>HIV/AIDS</td>
<td>0.62</td>
<td>Stroke and other cerebrovascular diseases</td>
<td>1.72</td>
</tr>
<tr>
<td>Colon and rectum cancers</td>
<td>0.26</td>
<td>Perinatal conditions</td>
<td>0.60</td>
<td>Diarrheal diseases</td>
<td>1.54</td>
</tr>
<tr>
<td>Alzheimer’s and other dementias</td>
<td>0.22</td>
<td>Stomach cancer</td>
<td>0.58</td>
<td>Malaria</td>
<td>1.24</td>
</tr>
<tr>
<td>Diabetes mellitus</td>
<td>0.22</td>
<td>Trachea, bronchus and lung cancers</td>
<td>0.57</td>
<td>Tuberculosis</td>
<td>1.10</td>
</tr>
<tr>
<td>Breast cancer</td>
<td>0.15</td>
<td>Road traffic accidents</td>
<td>0.55</td>
<td>Chronic obstructive pulmonary disease</td>
<td>0.88</td>
</tr>
<tr>
<td>Stomach cancer</td>
<td>0.14</td>
<td>Hypertensive heart disease</td>
<td>0.54</td>
<td>Road traffic accidents</td>
<td>0.53</td>
</tr>
</tbody>
</table>

Source: World Health Organization
African countries have average male life expectancies that exceed 60 years, and only three countries exceed 70 years.

As economies in the developing world expand and people live longer and are able to afford more treatment, the growing affluence will increase cancer rates. Even in the developed world, deaths from cancer will likely increase as drugs such as statins reduce deaths from competing illnesses such as cardiovascular disease (which remains the largest killer worldwide), and as death rates from related diseases such as chronic obstructive pulmonary disease are lowered by efforts to reduce smoking (see sidebar: The Stark Reality of Life-Saving Technologies).

**The Stark Reality of Life-Saving Technologies**

With nearly 650 drugs in development in the United States, the single greatest area of drug research is cancer. Cancer is composed of many hundreds of different genetic diseases, and great progress has been made in treating many types of cancer. For example, the life expectancy for women with breast cancer who have been diagnosed early now equals those who have never had the disease. However, there are still many difficulties in treating cancers for which the prognosis is poor.

Many cancer treatments involve surgery, radio-therapy and drug treatments. The current generation of new cancer treatments is dominated by additional therapies, not substitutes, which add more costs for each incremental improvement in life expectancy. As a result, sales of cancer drugs are increasing at roughly 12 to 15 percent a year. Similar trends can be seen in areas such as rheumatoid arthritis (where drug sales are skyrocketing).

New technologies that extend patient life will continue to become more available, but at ever-increasing costs. The demographic shift will burden the system even further as the number of older people demanding these technologies increases, while the number of people working to pay the bills shrinks. At some point, health systems that have so far managed to absorb rising costs will be unable to do so, making the rationing of these new, expensive technologies unavoidable.

To control these costs, an approach known as a health technology assessment (HTA), where analysts subject new technologies to a strict value-for-money evaluation, is becoming more common. Its leading proponent is the National Institute for Clinical Excellence in the United Kingdom.

The stark reality is that while patients want access to every technology that can keep them alive longer, citizens don’t want to pay for them. (Or, as the economist Tom Gotten puts it, “Health is an individual necessity and a national luxury.”) As a result, most developed world systems now, or will soon, face economic crisis, and will be forced to limit access to new technologies. The crisis facing European healthcare systems is not as immediate as the one facing the United States. With far greater levels of government control and ownership of healthcare assets, European countries are in many ways better placed to deal with the situation.

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7 Association of Breast Surgery and the NHS Breast Screening Program, April 2008.
emergence of a common healthcare model toward which all systems, with more or less reluctance, will move. Many healthcare stakeholders will find this transition deeply traumatic.

To understand what governments and other stakeholders can do, we reviewed the available literature on healthcare reform and analyzed 25 healthcare systems. We examined the approaches currently used by countries to improve efficiency and the reforms they are implementing. Our study identified 15 available approaches for reform, and found that systems adopt certain approaches depending on how well they fit with prevailing social norms (see figure 6).
The first approach—governments defining core services they will provide—easily ranks as the most contentious. Developing countries can afford to provide more health services for their populations as their wealth increases. Developed countries, on the other hand, face the opposite challenge of reining in the scope of their services. As governments become less able to guarantee universal access to all treatments, they will be pressured to break social contracts that have made such access a human right in many nations. With limited budgets, states will try to achieve the greatest “health return” by investing in areas with the most impact. They can make such decisions through objective metrics such as “cost per quality-adjusted life year” ($/QALY), emphasizing early intervention (vaccination programs, smoking cessation and screening), prevention (programs to deter suicide and reduce cholesterol and heart disease). Other priority areas include emergency and trauma care.

An unfortunate consequence of increasing wealth is that car accidents are now the leading cause of death for people age 10 to 24, according to the World Health Organization.

However, social preferences and politics also drive such choices, and few countries would deny children access to cancer care, no matter the prognosis or cost-effectiveness of treatment.

Organizations such as the World Health Organization, the Global Fund, and perhaps even the Gates Foundation will likely play a larger role in defining these core services. In developing countries, they will exert this power as paymasters, but in developed countries they may become an important reference point as healthcare systems seek to gain moral authority for difficult decisions.

All other approaches aim primarily at improving the efficiency of the health system. Eventually, countries will implement some combination of all of these approaches. As they do, healthcare systems around the world will converge on a common set of characteristics. We describe this common model as follows, based on the key stakeholders involved:

By 2020, much of the “old world” will indeed be old, as more than 20 percent of the population will be over 65 years of age.

Governments. Governments will provide universal core services such as emergency care, public health, prevention, mental health and support for disadvantaged groups. They will fund these services through a combination of general taxation and employer and employee contributions to mitigate the pain from either approach. Governments will also press employers to take more responsibility for maintaining their employees’ health.

Payers. Payers will consolidate to achieve economies of scale, forming monopoly or regional commissioners of care that distribute government funds. At the same time, a plethora of private, insurance-based services will focus on providing faster access and expensive, marginally
cost-effective services and lifestyle therapies. To control costs, both public and private payers will specify how care should be delivered.

Providers. Providers will include a mix of public institutions in healthcare areas where competition is not effective (such as emergency care) and private operators where competition works. State-controlled regional planning will organize the right balance of specialist centers, emergency services and primary-care facilities for each region, often with a focus on shifting care toward the community. Increasingly, providers will receive tariff-based (a set price) and capitated (a fixed, per-patient price) payments for their services, and enter into risk-sharing agreements.

Citizens. To keep demand in check, citizens will make higher copayments for medical services. Primary-care physicians will act as gatekeepers for access to expensive acute care. Citizens will also be encouraged and assisted either to pay for noncore services or purchase insurance to cover the costs.

Drug companies will no longer be able to assume that governments will fund new drugs, even those that prove innovative and effective.

Suppliers. Suppliers such as medical technology and pharmaceutical companies will contend with centralized procurement by commissioners, strict evaluations of cost-effectiveness, regulated prices where monopolies exist (for example with innovative drugs) and, in the case of pharmaceuticals, the use of generics.

While healthcare systems worldwide currently employ some or all of the 15 methods, the sheer complexity of healthcare system behavior makes it difficult to provide definitive evidence as to their effectiveness. However, observationally, whether they work or not, all health systems appear to follow the same pattern.

As the common model emerges, the key variable will be the content of the core services. Systems will use various approaches to justify what they include and exclude, but in reality the boundaries will be quite arbitrary (see figure 7).

Implications of the Common Model

The common model we envision poses far-reaching implications for participants in the healthcare value chain. Key stakeholders will have very different objectives:

Governments: prepare, scope and build consensus. Governments will have to accept that, eventually, they must employ a version of the common model. They can choose to make the transition either haphazardly or methodically. Naturally, most will begin to reform health policy in areas that are least controversial with respect to the local service history, political interests and prevailing ideology. For example, citizens in the United Kingdom will likely find paying for healthcare at the point of use very difficult, while in France copays are an essential element of the system. And while the United Kingdom has long used General Drug companies will no longer be able to assume that governments will fund new drugs, even those that prove innovative and effective.
Practice physicians as “gatekeepers,” the French and Germans are only hesitantly moving down this path. In many systems, private insurance already plays an integral and highly regulated role, while in Canada it is not allowed, and in the United Kingdom it is barely tolerated (but lightly regulated). The United States of course has a deep suspicion of state involvement in providing healthcare, while many European countries have an equal concern over private-sector involvement.

Eventually, however, the least-offensive options will be exhausted, leaving only the most unpopular. To prepare for that day, governments must help their citizens understand the importance of these choices long before they come to pass, and conduct an open debate about the trade-offs required. For example, governments will want to explore the potential scope of core services and reassess their role in maintaining health—balancing health economics and political realities in the allocation of spending. They must also clarify a variety of fundamental medical issues. For example, what counts as a “disease”? Infertility? Impotence? Disfigurement? How can health systems strike the right balance between prevention and cure? How crucial is preventing death in the terminal state, and which diseases are most important to treat? Governments will want to assist citizens and employers in the funding of noncore services, ensuring that access to costly treatments remains open to all.

These are all extremely difficult issues for governments to address. Typically, states have employed less explicit approaches such as

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**Figure 7**

Nations must determine core healthcare services

![Diagram showing core services for developed and developing countries](Image)

*HTA, or health-technology assessment, is a process governments use to assess cost-effectiveness of clinical interventions*

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establishing waiting lists to restrict demand, or encouraging other parties—such as insurance companies or health plans—to make the difficult decisions. But as their healthcare systems run out of money, governments will implement extensive reforms. To change their systems amid different and often competing objectives, it will be necessary to build political consensus and break up the stakeholder logjams that protect the status quo.

Pharmaceutical companies: align with future health needs. In recent years, the pharmaceutical industry— with few blockbuster primary-care drugs on the horizon— has shifted toward areas likely to be excluded from core services. These include secondary-care drugs targeted at ever-smaller groups of patients and increasingly expensive medicines that provide only modest incremental health gains.

As the common model becomes ubiquitous, drug companies will no longer be able to assume that governments will fund new drugs, even those that prove innovative and effective. Instead, companies must align their drug portfolios and prices to match the scope of core services and the priorities of the system in which they compete. Above all, companies must do everything possible to keep their offerings under the core-services umbrella— ensuring that the therapy area becomes a political priority, encouraging regulators to make decisions based not just on cost but on the total benefits of a therapy, and reducing non-drug-related costs to keep overall therapy costs down.

Drug pricing will become increasingly fluid and complex as different national systems negotiate the point at which core services end and private services begin. Furthermore, the developing world’s new mass markets will require far lower prices. Thus, companies will develop complex pricing mechanisms to maximize overall returns—a trend already occurring with HIV drugs that will spread to other therapies as epidemiology changes. For example, in March 2007, GlaxoSmithKline announced its “Tearing Down the Barriers” initiative to test tiered drug prices for different countries and market sectors, including the private and public health sectors. If price or other factors take a drug out of core services, pharmaceutical companies must work to ensure that private patients can still afford to pay for it (by providing financing, for example).

The emergence of the common model also puts at risk the successful medical innovation model of the past half-century. Because of high costs— driven in part by increasing regulatory supervision— companies that develop innovative medicines rely on near-guaranteed access to wealthy markets. In today’s market, governments can exclude expensive drugs without fear of

We predict the emergence of a common healthcare model toward which all systems, with more or less reluctance, will move.
disrupting investment, assured that companies will develop them anyway for the U.S. market. However, as the United States moves toward its own version of the common model, these innovations will likely fall by the wayside. Today’s often combative relationships must evolve into something much more mature and collaborative. Companies and governments will need to work together as partners to reduce regulatory costs and encourage new investment, moving beyond debates over pricing and toward discussions of lifetime cost and value.

Payers, providers and citizens: seize new opportunities. The emergence of the common model and an increasingly internationalized healthcare industry is mostly good news for private payers, with some notable exceptions. For example, insurers will enjoy new opportunities from the growth of private financing. However, where payer markets are fragmented, they will consolidate, squeezing out many competitors. In the United States, the expanding role of the state will dramatically change the industry’s structure.

The common model will also create new opportunities for providers, especially in markets where hospitals are generally government-owned. However, today’s mostly nationally based providers will also have to contend with more global competition.

For citizens, the news is mixed. Developing countries will expand core services and receive new therapies at lower costs than their developed counterparts. The uninsured in the United States will have more access to primary care, while citizens who currently receive most of their healthcare from state systems will spend more of their income on treatment. It is hard to see how this can be achieved without making care less equal.

A Threshold for Healthcare

While it seems unlikely that future medical care will resemble science-fiction’s Gateway model anytime soon, the $4.2 trillion global healthcare industry will soon reach its own gateway of sorts; beyond which easy options will be exhausted, and only tough choices remain. This threshold will affect every element of the health ecosystem. The rollout of this new model will undoubtedly cause disruptions and discontinuities throughout the healthcare value chain. But it is the role of government and industry stakeholders to recognize, prepare for and ultimately resolve challenges as they move toward a common healthcare model.

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