Critical Disruptions
The Five Forces Shaping Health Care's Future
Charles Darwin taught us that those who adapt survive, and those who don’t become obsolete. We’re accelerating into a period of significant change that will cause health systems to evolve in both subtle and dramatic ways.

The health systems that thrive will be those that successfully pinpoint and prepare for the critical disruptive forces reshaping care delivery.

We see health care facing five of these forces over the next 5 to 10 years and beyond.
Five Disruptive Forces Affecting Health Care

The Greying Patient (and Provider)

The New Health Care Consumer

The Lifestyle Epidemic

The Blessing and Curse of Clinical Technology

The Information Revolution
You’ve likely heard about these forces. Some are more complex than they seem, but the real challenge? Deciding when and how you will adapt.

Here’s a closer look at these pressures—and how you should plan for them.
Five Disruptive Forces Affecting Health Care

01 The Greying Patient (and Provider)
02 The Lifestyle Epidemic
03 The Information Revolution
04 The Blessing and Curse of Clinical Technology
05 The New Health Care Consumer
The Greying Patient (and Provider)

Most conversations about ageing and the health care industry focus on the patient population. They typically go something like this: “People are living longer than they ever have, and more people than ever are now entering their prime health care years, so we should brace ourselves for a surge in patients and spending.”

We’re pretty sure those factors will affect health care volumes and costs in the very long term. But when we focus on the short term—the next five to ten years of your career—we don’t think your greying patient population is the most pressing issue. **It’s your greying workforce.**

The imminent danger: Uneven age distributions

Age distributions around the world are changing dramatically. For example, the Organisation for Economic Cooperation and Development predicts that by 2050, there will be just two 20- to 64-year-olds for every person over 65. Right now, the ratio is about four to one.

Number of People 20–64 for Every Person Older Than 65

<table>
<thead>
<tr>
<th>Year</th>
<th>Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>1950</td>
<td>7.2</td>
</tr>
<tr>
<td>1980</td>
<td>5.1</td>
</tr>
<tr>
<td>2011</td>
<td>4.1</td>
</tr>
<tr>
<td>2050</td>
<td>2.1</td>
</tr>
</tbody>
</table>
Now, let’s look at a critical segment of this ageing population: your employees. Even with people working longer, health care leaders around the world tell us that both a rapidly ageing workforce and specific shortages in key positions rank high on their list of immediate concerns.

In Europe, for example, they’re feeling this in nursing. A European Commission report predicts a nursing shortage of more than half a million by 2020, and an overall clinical workforce shortage of nearly 1 million.

### Predicted 2020 Clinical Workforce Shortage

<table>
<thead>
<tr>
<th>HEALTH PROFESSIONALS OR OTHER HEALTH WORKERS</th>
<th>ESTIMATED SHORTAGE BY 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors</td>
<td>230,000</td>
</tr>
<tr>
<td>Dentists, Pharmacists, and Physiotherapists</td>
<td>150,000</td>
</tr>
<tr>
<td>Nurses</td>
<td>590,000</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>970,000</strong></td>
</tr>
</tbody>
</table>
“Without further measures to meet these challenges, the Commission estimates a potential shortfall of around 1 million healthcare workers by 2020 rising up to 2 million if long term care and ancillary professions are taken into account. This means around 15% of total care will not be covered compared to 2010.”

Action Plan for the EU Health Workforce, European Commission
If you want to see the future, go to the countryside. It can already feel like 2050 in rural areas where young people have fled for the city—elderly patient populations with few health care workers to provide for them. What’s more, lower birth rates mean fewer unpaid “carers”.

The Polish Doctor Who Makes 12-Hour Commute to Treat Patients in Britain

“In rural and deprived areas it is particularly hard to find British doctors to do the work, so foreigners increasingly fill the gaps. Dr Robinski, 40, is based in Poznan, Poland. Every second week, after working Monday to Thursday as a GP at home, he gets up at 4 a.m. on the Friday and begins his journey to Britain. He drives four hours to Wroclaw airport in south-west Poland, then takes a cheap flight to Glasgow which takes two hours and 20 minutes. Having arrived in Glasgow, he drives a hire car to Aberdeen, which can take him another four hours.”

China Faces ‘Timebomb’ of Ageing Population

“While hundreds of millions of Chinese families toasted the new year together, 84-year-old He Daxing huddled on the doorstep of his daughter’s home in Chongqing. On the most important date in the calendar, not one of his six grown children—born before the country’s one-child policy was imposed—would take him in...China may soon have more He Daxings. It faces a soaring number of old people and a shrinking number of young adults, who are also less able—and sometimes less willing—to support their elders.”
The **Lifestyle** Epidemic

Today, we’re wealthier than ever; we’ve (so far) avoided a major global war; and we have access to health care that would have been the stuff of science fiction a hundred years ago.

But we’ve also become more sedentary, and we’re polluting the atmosphere at an alarming rate. Meanwhile, our terrific health care is helping us live longer with chronic conditions like diabetes and heart disease.

This continuing rise of non-communicable or chronic disease will be the most important driver of global health costs in the coming years. Chronic disease is now the number one killer in virtually all countries, except a few where infectious diseases are still rife.

**Projected Leading Causes of Death Worldwide**

*All Ages, 2015*

Non-communicable diseases account for 76% of deaths worldwide.
So, as we see more patients suffering from multiple chronic diseases and requiring significant care, what needs to change?

**Preventive medicine top-of-mind, but not a magic bullet**

A popular proposal for treating a chronically diseased patient population is a more patient-centred system. This approach relies heavily on prevention.

In this vein, campaigns to provide patients with the knowledge and resources they need to manage their own care seem like they would prevent downstream acute care incidents. But that isn’t necessarily the case.

A study published in *Health Affairs*, for example, projected that a 25-year campaign against diabetes would actually increase a hospital’s costs for almost all age groups, once you factored in program expenditures.
Don’t dismiss the acute care hospital just yet

We’d all agree that the traditional health care system isn’t built to provide long-term, preventive care, so this movement may appear to announce the doom of the hospital. But, the acute care hospital will still play a significant role going forward.

The Australian Institute of Health and Welfare’s projection below shows health care expenditure growth broken down by various care types.

Projected Growth in Health Spending by Care Type

*In 2033*

<table>
<thead>
<tr>
<th>Care Type</th>
<th>Growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmaceuticals</td>
<td>10.6%</td>
</tr>
<tr>
<td>Residential Aged Care</td>
<td>13.8%</td>
</tr>
<tr>
<td>Out-of-Hospital Medical Care</td>
<td>11.0%</td>
</tr>
<tr>
<td>Admitted Patient Services</td>
<td>34.5%</td>
</tr>
<tr>
<td>Other^2</td>
<td>30.1%</td>
</tr>
</tbody>
</table>

**214%**

Increase in admitted patient services

**$7.6B**

Increase in spending on respiratory disease for admitted patients

**613%**

Increase in expenditures related in to inpatient diabetes treatment

More than one-third of overall growth will be in services provided to admitted patients. The next largest area of growth, “other”, incorporates outpatient care, dental, patient transportation, administrative services, public health, and other care practitioners.
The bigger picture: A high-performing care management network

Many organisations’ longer-term strategic considerations involve far more than just one acute care hospital, though. They include the full continuum of care and the operation of multiple, complementary health services.

The organising principle behind your health investments needs to address the patient types you’ll service in the future. Our research in population health management shows that health systems can divide their populations into three discrete groups:

**High-Risk Patients (5%)**

A relatively small number of patients requiring the highest-intensity care. These patients should be connected with a care team that can help shift high-cost utilisation to low-cost management—by connecting patients with accessible primary care, assigning them a dedicated care manager, and trying other interventions.

**Rising-Risk Patients (15%–35%)**

Those with one or two emerging comorbidities who may eventually rise to the high-risk pool. Rising-risk patients should be managed by a patient-centred, multidisciplinary team anchored in primary care to achieve efficient, economical care management and avoid unnecessary spending down the road.

**Low-Risk Patients (60%–80%)**

Patients for whom self-service care management will work. You should reinforce low-risk patients’ access to information and resources that will keep them healthy and connected to the system, creating a convenient experience that results in a high level of patient satisfaction.

This is what effective population health managers do well. They are highly targeted in their approach to care management, and they build efficient, lean infrastructures for patient care.
The Information Revolution

The more you know about a patient, the better care you can provide, so the big data revolution presents an enormous opportunity for the health care industry. But with patients rightly concerned about their autonomy and privacy, we must ask: Are patients prepared for a “smart” health care system? Are you?

So many areas within health IT promise to radically transform how we manage patients and our enterprises. It’s critical to understand health care organisations’ biggest opportunities and most daunting hurdles.

The Promise of Better Data and Analysis

- Clinical Decision Support
- Management Support
- Patient Empowerment
- Population Management
- Personalised Care
- Quality and Safety
- Coordination Within Continuum
The US discount retailer Target recently provided us with a lesson in what not to do with big data. Using its sophisticated in-house data management system, Target focused on new parents as a tremendous sales opportunity, and came up with a cluster of 25 purchases that would indicate when a woman is likely in her second term of pregnancy. Customers who bought those products then received coupons for things like diapers, baby lotion, and so forth.

But what if that pregnancy was unplanned? Sure enough, one day an enraged father came into a store shouting at a manager to stop sending his teenage daughter baby product coupons. The father later apologised. Target, it seems, knew more about his daughter than he did.

This wasn’t isolated. In general, women didn’t like Target knowing they were pregnant.

“If we send someone a catalogue and say, ‘Congratulations on your first child!’ and they’ve never told us they’re pregnant, that’s going to make some people uncomfortable. We are very conservative about compliance with all privacy laws. But even if you’re following the law, you can do things where people get queasy.”

Andrew Pole
Guest Marketing Analytics Manager, Target
Difficult to seize these opportunities without the necessary skill sets

When thinking about information technology investments, many organisations focus almost exclusively on the technology itself. But few organisations ask whether or not they’re transforming *themselves* to make the most of these advances. Encouraging staff adoption can be difficult, especially when technology requires a change in workflow, involves standardisation, or is introduced by an IT specialist without clinical credentials. Consider the divergent perspectives at work here.

Clinical Information Technology Competencies Required

<table>
<thead>
<tr>
<th>COMPETENCIES</th>
<th>BARRIERS</th>
</tr>
</thead>
</table>
| **IT Workforce** | • Extracting and merging data  
• Building the technical system  
• Maintaining systems operations | • Lack of clinical expertise  
• Different culture  
• Opaque workflow visibility |
| **Clinical Workforce** | • Understanding clinical workflow  
• Using clinical data effectively  
• Providing feedback to improve system | • Rarely technical experts  
• Time constrained  
• Lack of engagement |

Bringing these roles together requires someone whose skills bridge both of these workforce segments: a clinician with enough authority and medical experience to win hospital staff support and an innovator who can focus on the intersection of operations and technology. In short, a chief medical information officer.
The **CMIO**: Uniting Medicine and Technology

With plans to roll out Australia’s first integrated digital hospital in 2014, UnitingCare Health recognised the need for a clinical leader to spur change through clinical improvement. Meet Dr. Monica Trujillo, Australia’s first chief medical information officer.

**Dr. Monica Trujillo**  
*Chief Medical Information Officer*

- Trained in hospital administration and public health
- Led EMR adoption in public system; selected to lead the IT rollout of Australia’s first HIMSS 6 digital hospital
- Dual role of regional Director of Medical Services group-wide CMIO; splits week across both roles
- Dedicated role as CMIO involves engaging doctors in EMR planning and adoption

“If it had been an IT person, that clinician wouldn’t have given him the time. He wouldn’t have even listened. I’ve been at the other end where someone, and it’s just that fact that they’re coming to tell me what they think is better for me and my practice, and it’s not the way it works.”

So what does a CMIO do? Here’s one example. A doctor on Dr. Trujillo’s team was hesitant to use an online ordering system for his weekly surgery. She decided to sit down with him.

“Look, I guarantee you if I go through three weeks of your handwritten orders, I’m going to find you missed something,” she said. “With one click on this page, you can have the exact same order—every item—automatically requested.”

He came around shortly after that, and Dr. Trujillo attributes her success to the dedicated time she made to meet with her colleague, challenge him as a clinician, and convince him that this technological solution had positive clinical ramifications.
The Blessing and Curse of Clinical Technology

Clinical technology is always the part of hospital management that sparks executives’ imaginations the most. It will be a very important long-term driver of change, but it’s unlikely to be the most important one on the 10-year time horizon. Here’s why.

The last 50 years, which we’ll call the Mechanical Era of Innovation, have brought both wonderful techniques and treatments—especially in the fields of surgery, radiology, and radiation therapy—and huge growth in health spending.

Components of Annual Growth in Real per Capita Health Spending³
1960–2007

But when it comes to clinical technology innovation, have we reached terminal velocity? All signs point to a slowdown, where we’ll see incremental technological advances focused on throughput, cost management, and patient safety.

Take radiology, for example. CT vendors have stopped trying to outdo each other, partly because they’ve reached a technical plateau but also because hospitals are more interested in efficiency and cost reduction.
Even with a slowdown, though, hospitals can expect to see a lot of investment ahead as technologies drop in price, new evidence fuels acceptance of technologies, and organisations progress along the adoption curve.

**CASE IN BRIEF**

**Duct Tape: An unlikely ‘innovation’**

It’s been said that duct tape isn’t a perfect solution for anything, but it’s a good solution for just about everything. Including warts. A number of trials have shown that occluding a wart using duct tape is not only much cheaper than having warts surgically removed, treating them with antivirals and lasers, or using cryotherapy, it’s also more effective and less painful.

**Duct Tape Versus Cryotherapy**

<table>
<thead>
<tr>
<th>Efficacy Comparison of Wart Treatments</th>
<th>Cost Comparison of Wart Treatments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duct Tape</td>
<td>85%</td>
</tr>
<tr>
<td>Cryotherapy</td>
<td>60%</td>
</tr>
</tbody>
</table>

Sadly, most new clinical technologies aren’t duct tape. They’re almost never cheaper, more effective, or less painful than their predecessors—they require a thoughtful, strategic approach to adoption.
Out with the old and in with the new...biotechnical era

While we are nearing the end of the mechanical era, we are on the verge of a new biotechnical era, where care solutions will draw on an individual’s biology to cure disease.

Revolution Approaching, but Not Here Yet

<table>
<thead>
<tr>
<th>Premium Implants</th>
<th>Advanced Imaging</th>
<th>Robotic Surgery</th>
<th>Radiation Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Made of more durable/premium materials</td>
<td>More resolution, greater coverage</td>
<td>Greater precision in surgical tool manipulation</td>
<td>Increased targeting and accuracy</td>
</tr>
</tbody>
</table>

1960 2012 2050

Mechanical Era

Biotechnical Era

<table>
<thead>
<tr>
<th>Stem Cells</th>
<th>Molecular Medicine</th>
<th>Gene Therapy</th>
<th>Tissue Engineering</th>
</tr>
</thead>
<tbody>
<tr>
<td>Novel therapies using self-renewing stem cells</td>
<td>Targeted and tailored therapies using molecular interventions</td>
<td>Treatments using DNA as a pharmaceutical agent to treat disease</td>
<td>Growing tissue from base-elements</td>
</tr>
</tbody>
</table>

Gene therapy, for instance, may silence genes responsible for defects or activate those that suppress illnesses. Administered virally, the technique could one day cure certain cancers, Parkinson’s disease, and even colour blindness, among other things.

Then there are mouse “avatars” that are bred with a genetic pattern similar to a particular patient’s so doctors can use them to figure out what treatment will work best for that individual. And bioprinters, which build on 3D printing technologies to produce new organs and blood vessels.

You can imagine how disruptive these advances would be—think about using stem cells to grow patients new joints or lungs—but there’s no need to do a lot of planning for this yet unless you are with an advanced research institute.
Genetic testing, however, is already on the rise—and could actually add cost to the system by creating an increase in unnecessary procedures. Then there are ethical questions: What if a patient tests positive for the Alzheimer’s gene? Should patients pursue a double prophylactic mastectomy when they test positive for a BRCA1 or BRCA2 gene mutation?

Doctor Expectations of Genetic Testing’s Impact on Future Health Care Costs

\[ n=1,254 \text{ Doctors} \]

CASE IN BRIEF

Preventative Mastectomy

Angelina Jolie made international headlines when she announced that she’d undergone a double mastectomy after testing positive for the BRCA1 gene. Certainly, she inspired women around the world to consider the same treatment. Should your hospital be prepared to answer this call?

- Approximately 7,500 women in the UK undergo genetic testing for breast cancer each year
- 20% of women who undergo testing have a BRCA1 or BRCA2 gene mutation, which increases their cancer predisposition, and 30% to 40% of those opt for prophylactic double mastectomy
- Angelina Jolie, international movie icon, underwent double mastectomy this year after discovering she has a genetic mutation predisposing her to breast cancer
The New Health Care Consumer

The Internet has driven consumer expectations sky-high. Patients want information quickly and on demand, and they want to use it. What does this all mean for hospitals and health systems?

Today’s patient is Google-informed...

If knowledge is power, patients are more empowered than ever. A 2012 German study found that patients who used the Internet to learn about their illness prior to medical consultations directly influenced the outcome of those consultations.

And patients often walk in with good information. A father’s correct diagnosis of his son’s rare condition, for example, prompted a 2006 *BMJ* study that tried to determine whether Google is a reliable way to figure out what’s ailing you. More often than not, apparently, it is.
...and Walmart-enabled

Self-care also goes hand-in-hand with a highly informed and empowered patient population.

According to Deloitte, almost 90% of patients are interested in technology that will help them avoid doctor visits. Not surprisingly, Walmart—the world’s third-largest public corporation and largest retailer—is capitalising on this trend.

Walmart has rolled out thousands of health diagnostic kiosks across the United States. The theory: shoppers will stop to check their eyesight and body mass index, for example, and then purchase items accordingly.

This isn’t entirely new; pharmacies, for instance, have long offered self-serve blood pressure readings. But consumers typically go to the pharmacy only when they have some sort of health need. Walmart is making self-service health care assessments part of customers’ normal retail routines.

This paves the way for other disruptive self-service products. For example, NowClinic—a subsidiary of U.S. health insurer UnitedHealth Group—charges $45 for a 10-minute live online video doctor consultation.
Transparency is the new way of life

Transparency is another consumer-driven phenomenon worth considering. There’s more information than ever out there about patients’ perceptions of your organisation’s performance. Put another way, your hospital probably has or will one day have a Yelp rating.

We are seeing this already through increased attention in the media, particularly when it comes to quality incidents. Holding hospitals to account for bad outcomes is appropriate. But the chart below speaks to one adverse effect: the public’s increased exposure to hospital missteps is eroding trust.

Perceived Likelihood of Adverse Events

n=26,663

<table>
<thead>
<tr>
<th>Event</th>
<th>Likely</th>
<th>Not Likely</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Infections</td>
<td>59</td>
<td>38</td>
<td>3</td>
</tr>
<tr>
<td>Incorrect, Mixed or Delayed Diagnosis</td>
<td>58</td>
<td>39</td>
<td>3</td>
</tr>
<tr>
<td>Medication Errors</td>
<td>49</td>
<td>48</td>
<td>3</td>
</tr>
<tr>
<td>Surgical Errors</td>
<td>46</td>
<td>50</td>
<td>4</td>
</tr>
</tbody>
</table>
Because this feedback is emerging at a time when quality has arguably improved, the distrust likely stems from the general increase in health care industry transparency, combined with media-driven exposure of poor quality instances.

Regardless of the cause, however, it’s still a major shift in public opinion. As you can tell by the examples of attempts to measure and manage quality detailed below, governments worldwide are feeling pressure to demonstrate—and improve—the quality of hospital care.

### Global Quality Metrics

<table>
<thead>
<tr>
<th>Country</th>
<th>Index</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>152</td>
<td>Australian Council of Healthcare Standards</td>
</tr>
<tr>
<td>Canada</td>
<td>16</td>
<td>Institute of Health Performance</td>
</tr>
<tr>
<td>Denmark</td>
<td>40</td>
<td>National Indicator Project</td>
</tr>
<tr>
<td>Germany</td>
<td>34</td>
<td>Cross-Sector Quality in Health Care</td>
</tr>
<tr>
<td>Netherlands</td>
<td>26</td>
<td>Performance Indicators on Patient Safety and Effectiveness</td>
</tr>
<tr>
<td>Sweden</td>
<td>134</td>
<td>National Healthcare Quality Registries</td>
</tr>
<tr>
<td>Switzerland</td>
<td>30</td>
<td>Federal Office of Public Health</td>
</tr>
<tr>
<td>United States</td>
<td>44</td>
<td>Centers for Medicaid and Medicare Services</td>
</tr>
<tr>
<td>World Health Organisation</td>
<td>35</td>
<td>Performance Assessment Tool for QI in Hospitals</td>
</tr>
</tbody>
</table>

26 Safety Improvement for Patients in Europe

54 EUPHORIC Project

343 EUNetPaS

35 World Health Organisation: Performance Assessment Tool for QI in Hospitals
The new status quo: Competitive transparency

We think something like the following league table will increasingly be a part of every organisation’s future, with each hospital’s ratings publicly compared against that of its peers in a bid to increase transparency and improve performance.

The reality for hospitals in many countries now is that transparency quickly leads to penalties and rewards. In other words, we believe hospitals will increasingly pay for poor quality both financially and through the shortened careers of their leadership.
### Sample League Table

<table>
<thead>
<tr>
<th>HOSPITAL NAME*</th>
<th>MORTALITY RATE</th>
<th>AVERAGE A&amp;E WAIT TIME</th>
<th>EMERGENCY READMISSION RATE</th>
<th>C.DIFFICILE RATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boshier Hospital</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Drexler Health Centre</td>
<td>✗</td>
<td>✔</td>
<td>✗</td>
<td>✓</td>
</tr>
<tr>
<td>Lindner Hospital</td>
<td>✔</td>
<td>✗</td>
<td>✔</td>
<td>✗</td>
</tr>
<tr>
<td>Strider Care</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✔</td>
</tr>
<tr>
<td>Thiebaud Care System</td>
<td>✔</td>
<td>✗</td>
<td>✔</td>
<td>✗</td>
</tr>
</tbody>
</table>

*Pseudonym.*
From Five Disruptive Forces to Six Major Questions

Taken collectively, all these trends raise a number of important strategic questions for the health system:

1. How will we navigate the (inevitable) mismatch between supply and demand for our services across the next 10 years?

2. How can we sustain appropriate investment in costly acute care services in an era of radical budget constraint?

3. Can we create an information-powered health system quickly enough to meet patient and purchaser expectations?

4. What model of care do we intend to invest in?

5. How “patient-centred” are our institutions? How “patient-centred” should they be?

6. Facing constantly shifting priorities, how can we set long-term strategy for our institutions?

So how can you begin to answer these questions and prepare for the future?
The case for calm versus the race to reform

Dr. William Baumol, an American economist, might recommend doing nothing. He suggests that, as a service-based industry, health care is incredibly resistant to productivity improvements relative to other parts of the economy. Over time, we'll spend more on health care. But we'll be able to afford it because the economy will continue to grow while goods in other sectors become cheaper.

Policymakers, however, have had a different response. They look at health care cost projections, see the trends described here, and react by instituting reforms that are often heavily influenced by countries struggling with similar issues.

Policy Migration Between Selected Countries

» Australian case mix system adopted in Germany
» German polyclinics a model for London
» Dutch reforms influence US policymakers
» U.S. Hospital readmission penalties adopted in the UK
» British four-hour A&E wait time target adopted in Australia
Building the Innovation Action Plan

**Adapting to the Immediate Challenge**
- Reducing unwanted variability
- Leveraging clinical data
- Delivering high-value care services
- Developing clinical excellence

**Developing a New Genetic Code**
- Evolving footprint across the care continuum to meet population need
- Leveraging data to address changing care needs, capturing new opportunities
- Remaking clinical work and recasting clinical roles for future care

**Taking the Evolutionary Leap**
- Extending health to patient home, neighborhood
- Driving continuous innovation

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ADAPTING TO THE IMMEDIATE CHALLENGE

DEVELOPING A NEW GENETIC CODE

TAKING THE EVOLUTIONARY LEAP

---

Time

Adaptation to New Environment

Perfecting Clinical Processes

New Physical Footprint

New Information Assets

New Clinical Workforce

Re-imagining the Health System
A new breed of health system

Realistically, standing still is not an option. But neither is simply shifting with the changing winds.

There are clear tasks at hand. Regardless of what happens policy-wise, we know that there will still be acute care to provide, and organisations will need to deliver it more efficiently than ever. That’s the core of our work, and it always will be.

But the next stage will involve doing things differently—building the assets, relationships, and skills that we’ll need to thrive in a new environment. Then, when the time is right, we should consider taking an evolutionary leap to fill a new role in society.

No other institution is more integrated into our communities than the health system or holds more responsibility for the wellness of those living in it. By evolving, we can ensure that the high quality health care we provide endures.
Global Forum for Health Care Innovators

Our global perspective and position as an industry thought leader enable us to help executives manage day-to-day operations while redefining longer-term organisational strategy to thrive in a new care environment. Here are a few of the ways we support your team.

**International meetings and global networking**
Attend day-long retreats for high-value opportunities to network with leading global health care providers. Hear unfiltered peer perspectives on acute organisational issues.

**Research and Insights**
Our team of experts offers thought-provoking and cutting-edge insights for an executive audience. Get thoughtful guidance on how to advance care integration within the constraints of market policies and payment models.

**Expert guidance**
Working on an initiative but don’t know where to begin? We offer unlimited telephone and email consultation and live executive team briefings to assist members seeking to implement ideas from our research at their own organisations.

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Charles Darwin taught us that those who adapt survive, and those who don’t become obsolete. We’re accelerating into a period of significant change that will cause health systems to evolve in both subtle and dramatic ways.

The health systems that thrive will be those that successfully pinpoint and prepare for the critical disruptive forces reshaping care delivery.

We see health care facing five of these forces over the next 5 to 10 years and beyond.
Critical Disruptions
The Five Forces Shaping Health Care's Future