

How keeping health a priority is a prescription for European prosperity

As Europe emerges from the pandemic, investing in health can not only save lives and build greater resilience but underpin economic growth and prosperity

by Hemant Ahlawat, Oscar Boldt-Christmas, Penny Dash, Martin Dewhurst, Grail Dorling, Jaana Remes, and Sven Smit



As destructive as the COVID-19 pandemic has been, it offers an important lesson as Europe looks forward to economic recovery, especially now that mass vaccinations are gaining momentum. Health and the economy are inextricably linked. While the final health and economic toll is still unknown, in the first year of the pandemic more than half a million lives were lost in Europe, and [Europe's GDP fell 7.5 percent](#). Yet what may not be widely appreciated is that each year, poor health costs the European economy on average about twice as much or about 15 percent of GDP from reduced quality of life, premature deaths, and lost productivity. As Europe emerges from the current health crisis, there is an opportunity not only to fix the problems exposed by the pandemic but also to save lives, improve overall quality of life, and build greater resilience against future health crises, all while promoting economic growth and greater prosperity.

In this article, we build on the McKinsey Global Institute's global report, *Prioritizing health: A prescription for prosperity*¹, to look more closely at Europe and identify what it would take to improve the health of the European population and what the benefits would be for individuals, the economy, and society. (See sidebar, "Our methodology.") We focus on the 27 member states of the European Union, Switzerland, and the United Kingdom. We analyze disease burden and economic forecasts over two decades to 2040 to identify challenges and opportunities at the country level and aggregate findings for the region as a whole.

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1. The \$2.7 trillion annual cost of poor health

The COVID-19 pandemic is an extreme example of how health, and the measures taken to control and suppress the spread of an infectious disease, can affect the economy. However, even before the pandemic, poor health cost Europe on average about \$2.7 trillion, or 15 percent of GDP a year, in lost

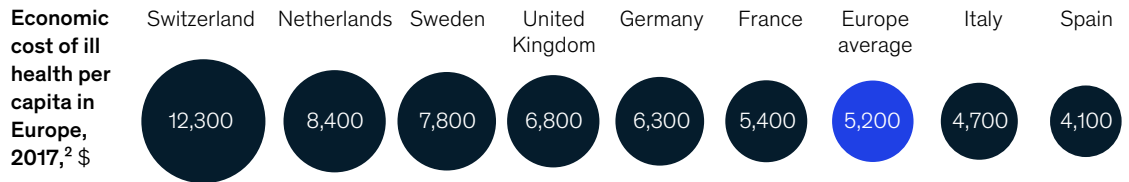
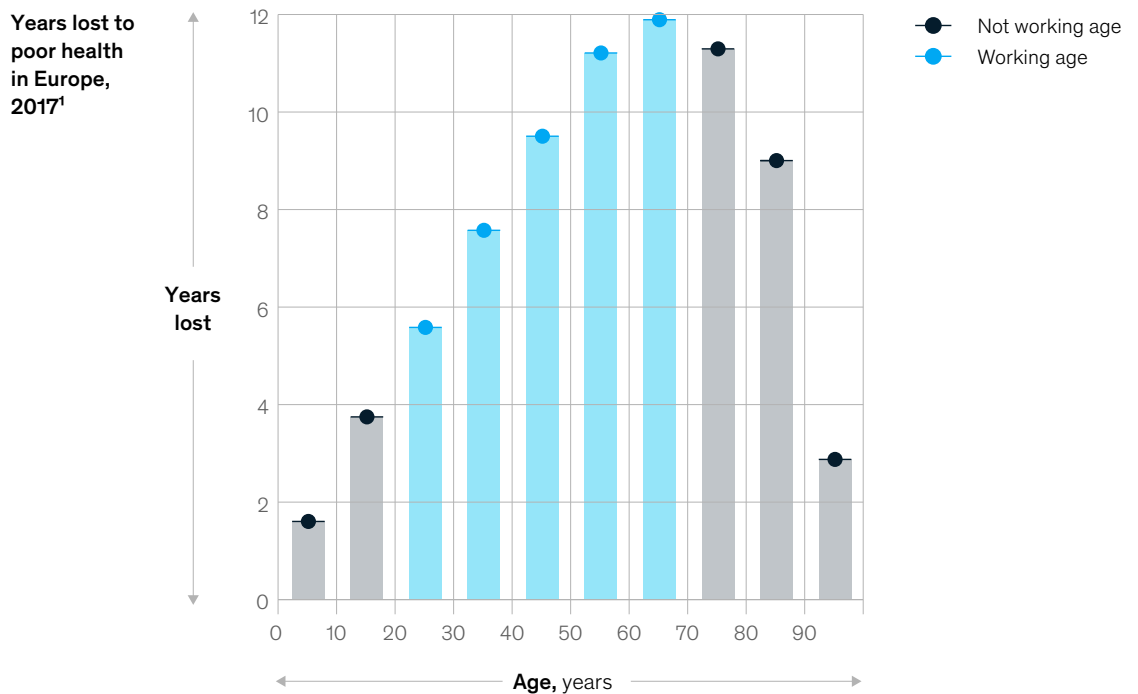
economic opportunity, equivalent to about \$5,000 per person (Exhibit 1).

Poor health reduces economic potential by keeping people out of the workforce, reducing productivity, and lowering earning potential. For example, a person may leave the workforce temporarily or permanently as a result of poor health, or move to a less physically or emotionally demanding role with lower remuneration. Others may reduce their

Exhibit 1

Almost two-thirds of years lost to poor health occur in the working-age population, resulting in an economic cost to Europe of \$2.7 trillion per year.

Baseline disease burden and economic cost, 2017



Note: Europe (here and throughout) defined as EU27 plus United Kingdom and Switzerland. Figures may not sum to 100% because of rounding.
¹Years lost to poor health is the sum of years lived with disability and years of life lost in this year due to premature death.
²Calculated for 2017; includes cost from loss of labor supply from early deaths in 2017, poor health and loss of productivity; does not include healthcare costs to address ill health.
 Source: Global Burden of Disease, 2016, Institute for Health Metrics and Evaluation; World Bank; McKinsey Global Institute analysis

work-related commitments to care for dependents who are living with poor health and disability. Premature mortality, in addition to being a tragedy, affects the size of the workforce and therefore economic output.

Our analysis looks exclusively at the lost economic opportunity of poor health in the labor market, including the overall supply of labor, unemployment, underemployment, and productivity. Poor health also affects people's lives in many noneconomic ways, by causing pain and worry, lowering independence, and limiting people's capacity to participate in daily activities, enjoy life, and realize their individual potential.

2. The health improvement opportunity

Three conditions have a disproportionate economic impact and collectively are responsible for more than half of all the lost economic potential due to poor health in Europe. These are: musculoskeletal disorders, particularly low back pain and neck pain, accounting for 24 percent of the total economic loss from poor health; mental health disorders, such as depression and anxiety, accounting for 18 percent; and neurological disorders such as migraine and headache, accounting for 13 percent.

These three conditions are relatively common, predominantly affect people of working age, and have a relatively high impact on daily life and productivity because they tend to be associated with chronic pain and distress. [A longitudinal study](#) conducted in the United Kingdom found that the conditions are significant predictors of early retirement, with more than half of early retirees reporting one or more of them. Similar patterns are found in [Germany](#).

Contributing to the overall disease burden are high levels of preventable health risks, particularly [excess weight and obesity](#), which exist across Europe and affect all social groups, though disproportionately those in [lower socioeconomic cohorts](#). [A survey of older adults](#) (aged 50+) in 20 European countries found that four out of five respondents reported living with a chronic condition and half of those aged 50+ were living with multiple long-term conditions.

The impact of Europe's underlying health vulnerability was exposed during the pandemic. People with [obesity](#) were estimated to be about 40 to 90 percent more likely to experience severe disease and death compared to their lower weight and healthier peers.

3. Prevention is key

We estimate that the health burden could be reduced by about 30 percent over the next two decades with more timely and consistent application of interventions available today. A 30 percent reduction in the expected disease burden would lead to tremendous health improvements. An average 65-year-old in Europe in 2040 could be as healthy as a 55-year-old today, and 11 million more people would be alive by 2040.

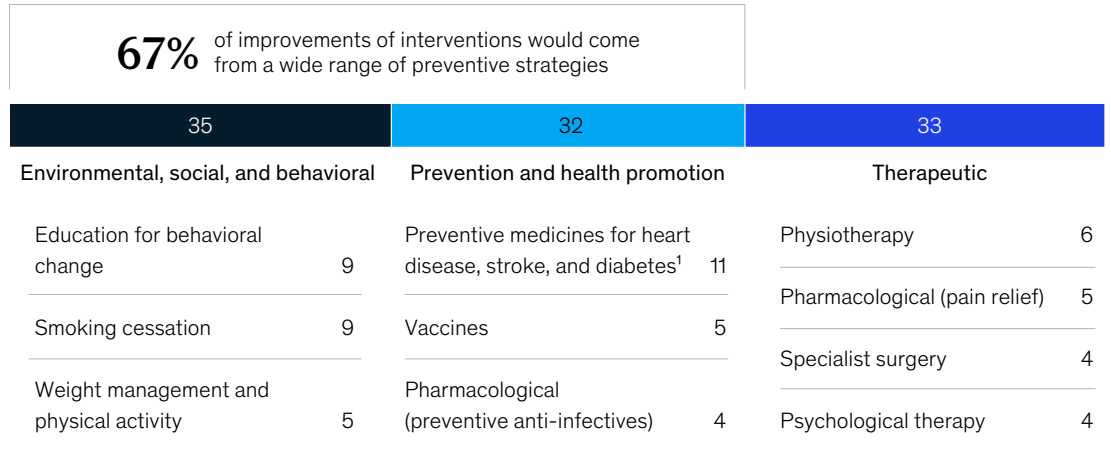
Almost all of this potential health improvement—about 85 percent of the total—would arise from addressing avoidable ill health related to noncommunicable diseases, such as heart disease and stroke, diabetes and its complications, chronic respiratory conditions including chronic obstructive pulmonary disease (COPD) and asthma, cancers, musculoskeletal conditions including chronic pain, and neurological disorders including dementias, migraine, and headaches. The remaining 15 percent would result from reducing injuries from road traffic accidents, falls, and self-harm, and reducing the risk from infectious diseases, addressing nutritional deficiencies, and making childbirth even safer.

Our research suggests that two-thirds of the improvement opportunity lies in areas of health promotion, prevention, health literacy, and healthier environments with more consistent, comprehensive, and early use of widely available and highly cost-effective strategies (Exhibit 2). Investment in creating the conditions for health could reduce disparities in health outcomes between different groups, relieve pressure on acute health services, and increase resilience in the face of future health-related challenges and shocks.

Exhibit 2

Two-thirds of health-improvement potential from known interventions would come from a wide range of preventive strategies.

Impact by intervention type, Europe, 2040, %



¹Including antihypertensives, medicines to control cholesterol levels, and medicines to control blood glucose levels. Source: Global Burden of Disease, 2017, Institute for Health Metrics and Evaluation; McKinsey Global Institute analysis

4. Innovation remains an imperative

Even if preventive and therapeutic interventions deliver as anticipated, we estimate that about 50 percent of all ill health forecast in Europe in 2040 is not addressable with the tools and solutions at hand or coming onstream in the next few years. That means innovation remains an imperative for improving health.

Based on today’s innovation pipeline, our analysis indicates that the burden of poor health could be reduced by a further 20 percent. The pace and efficiency of implementation could also be enhanced, particularly if the acceleration in the use of digital and data in health, catalyzed by the COVID-19 crisis, continues to drive toward fuller transformation of our approach to health and care that is more proactive and preventative, informed by data and intelligent analytics, and centered on the patient.

Our estimate is based on a systematic survey of current pipelines in clinical research and

development to understand future innovations. [We identified ten categories of technologies:](#) omics and molecular technology, next-generation pharmaceuticals, cellular therapy and regenerative medicine, innovative vaccines, advanced surgical procedures, connected and cognitive devices, electroceuticals, robotics and prosthetics, digital therapeutics, and tech-enabled care delivery. In each of these areas of innovation, small-scale pilots and applications already exist. For instance, surgical robots are being used successfully for a variety of surgeries, especially treatments for prostate cancer. Today about 20 advanced therapies based on omics and molecular technologies as well as cell therapy are on the market in the United States, including gene therapies targeting muscular atrophy and a genetic vision disorder, and cell therapy targeting leukemia.

5. How big is the economic prize?

We calculate that better health could contribute \$2.4 trillion to Europe’s GDP by 2040, equivalent to a 10 percent boost or an additional 0.5 percentage point of annual growth above current projections, and reverse an expected contraction of the labor force. There are four channels of economic impact from health improvement (Exhibit 3):

- Fewer health conditions. Lower levels of poor health in the population would reduce sick leave and absences from work as well as long-term disability. This channel accounts for 29 percent of the total economic impact from health improvement.
- Fewer early deaths. Because average life expectancy is already relatively high in Europe compared to other parts of the world, and considerably in excess of typical retirement age, this channel has a relatively small economic impact, contributing just 5 percent to the total economic impact.
- Expanded labor force participation. If more people were healthier for longer and fewer employment opportunities were curtailed by the need to provide informal care, we anticipate

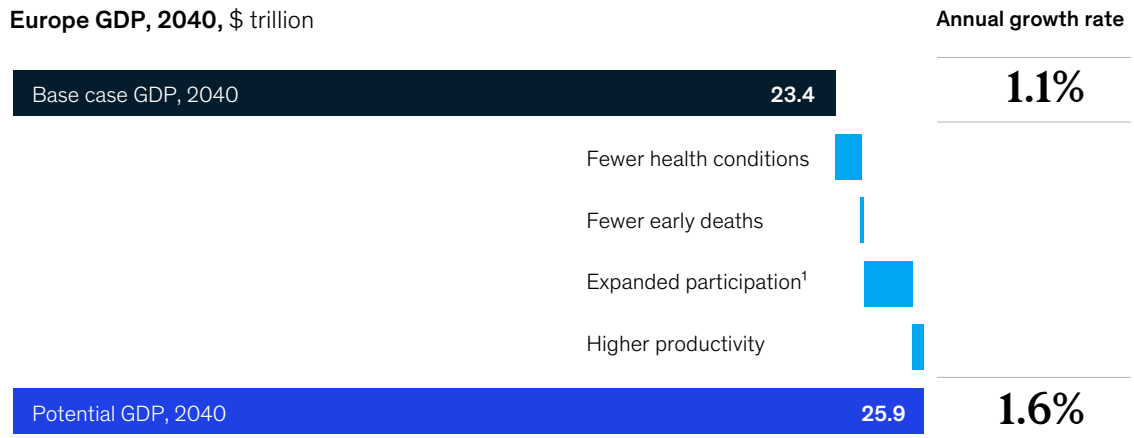
that more people may choose to work, and to work for longer, to find personal fulfillment and to increase their income at retirement. If the effective age at retirement shifted out by five years on average, combined with higher rates of economic participation for people with disabilities and informal caregivers, we estimate that this could boost GDP across the region by \$1.3 trillion, 53 percent of the total economic impact. Health improvement at this scale could reverse expected labor force shortages in Europe over the next two decades, amounting to a 10 percent boost in the size of the workforce by 2040 (Exhibit 4).

- Higher productivity. Finally, the impact of improved health on health-related presenteeism could contribute 14 percent of the total economic impact through improved productivity of the workforce.

The opportunity to unlock economic growth is shared across the region, with all 29 countries seeing a boost to GDP in 2040 of 5 to 16 percent from investing in improving health (Exhibit 5). Country-level differences in the scale of additional growth depend on a range of factors, including the underlying age structure and health profile of the population, as well as the levels of addressable

Exhibit 3

Europe’s GDP could rise by about \$2.4 trillion in 2040, a 10 percent increase, equivalent to 0.5 percentage points of additional growth from 2020 to 2040.

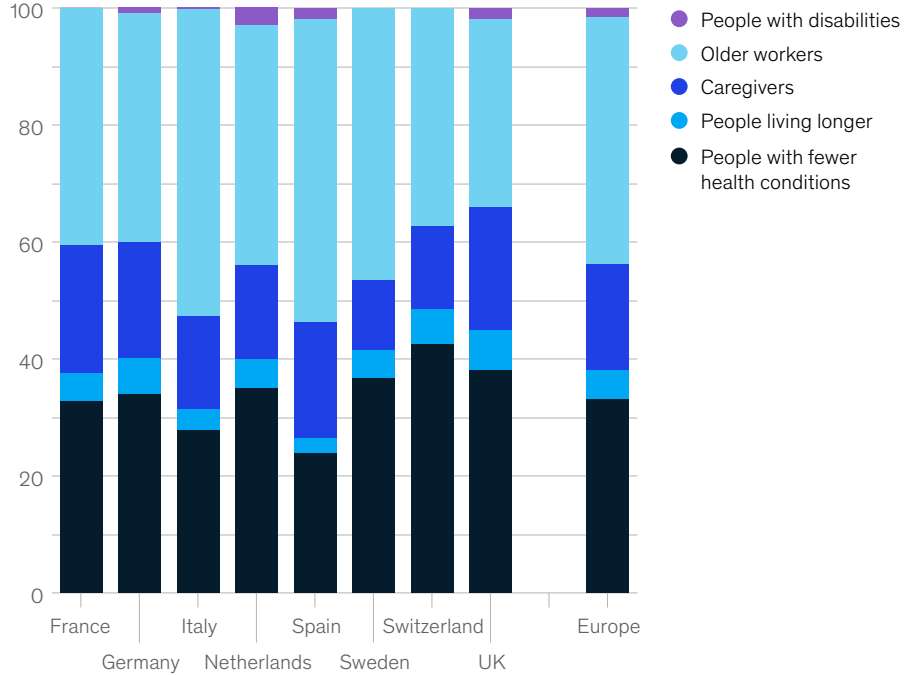


¹Includes impact from older adults, informal caregivers, and people with disabilities.
Source: Global Burden of Disease, 2016, Institute for Health Metrics and Evaluation; ILOSTAT; Oxford Economics; McKinsey Global Institute analysis

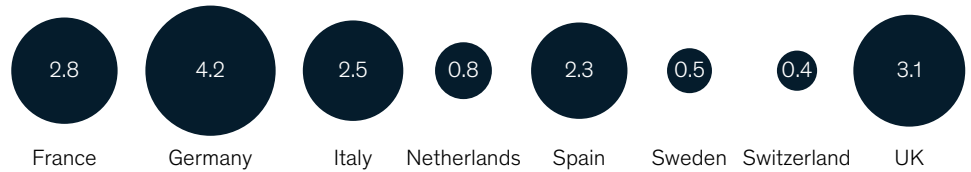
Exhibit 4

Health improvements could drive a labor-supply increase of 23 million people in Europe, a 10 percent boost.

Additional people participating in the labor force by source, 2040, %



Additional people in the labor force by source, 2040, million



Note: Figures may not sum to 100% because of rounding.
 Source: Eurostat; Global Burden of Disease, 2016, Institute for Health Metrics and Evaluation; ILOSTAT; National Transfer Accounts Project; Organisation for Economic Co-operation and Development; Oxford Economics; McKinsey Global Institute analysis

poor health in working-age groups and those in later middle age combined with levels of economic participation in later middle age cohorts.

While harder to measure, the societal benefits from these health improvements far exceed the economic benefits and may be about \$8 trillion by 2040. Beyond the capacity to work and increase their earnings potential, better health would give people the freedom to spend their leisure time on what they want to do most. This includes older people, many of whom may choose to give back to society in other ways after retirement.

6. The benefits outweigh the costs

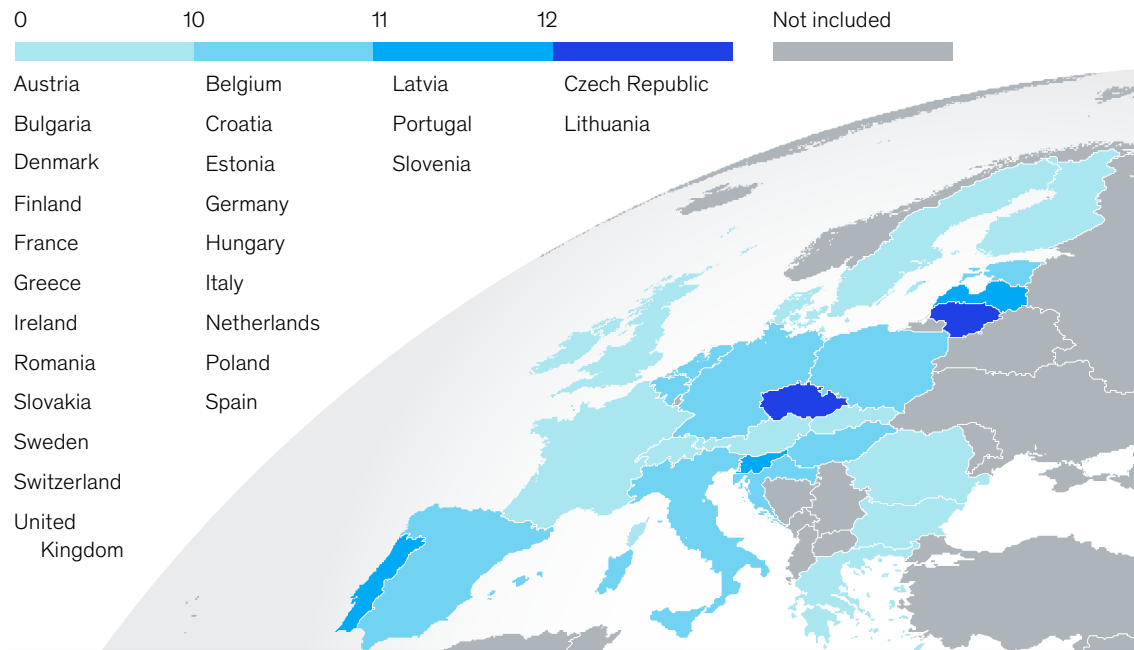
We estimate that for every dollar invested in improving the health of the population in Europe, about \$2.50 in economic benefit could result. Our analysis shows that in Europe and other high-income regions, between 50 and 60 percent of the total health improvement that could be achieved with wider uptake and more consistent adoption and adherence to existing interventions could be delivered for less than \$1,000 per healthy life year gained (Exhibit 6).

In many European countries, cardiovascular disease prevention, diabetes prevention, and aggressive

Exhibit 5

The GDP growth opportunity from health improvement varies across the region.

Range of estimated GDP growth potential by country by 2040, %



Note: The boundaries and names shown on this map do not imply official endorsement or acceptance by McKinsey & Company.
Source: McKinsey Global Institute analysis

smoking cessation strategies have the potential for very high impact. For example, an initiative in the Netherlands that provides daily remote monitoring and coaching for cardiac patients at home has led to a 52 percent reduction in hospital admissions, 26 percent lower costs, and high levels of patient and clinician satisfaction. At the same time, there is a need to address overuse of some therapies and in particular antibiotics, where there is a risk that patterns of use today will create new health threats in the future, [increasing the risk of antimicrobial resistance](#) and depleting the arsenal of treatments available for serious infections.

However, this does not mean additional funding for healthcare as currently delivered. The health benefits and the economic upside we calculate will not be possible without fundamental changes in not just where and how healthcare is delivered today, but also in how we build communities that help individuals grow up, work, and age in healthy ways.

7. How to capture the healthy growth opportunity

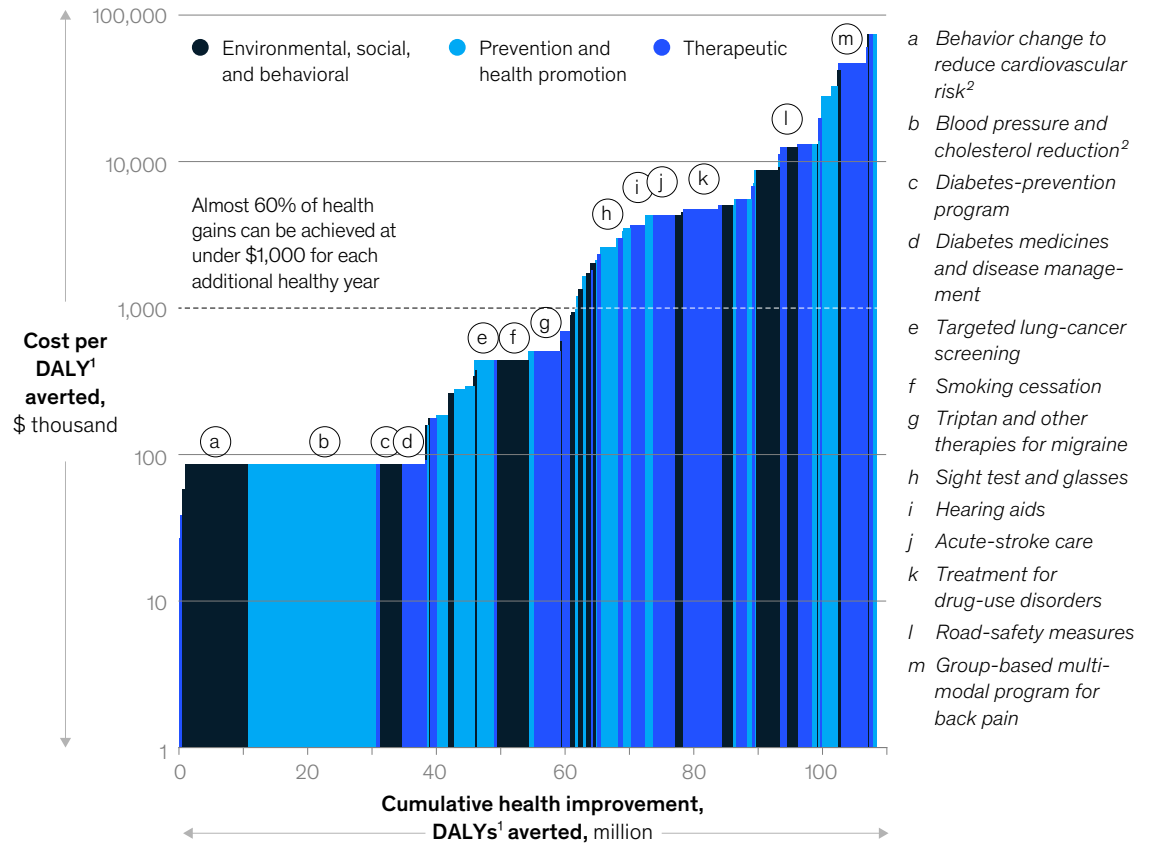
Health economists have long understood the role of rising life expectancy and improvements in population health in driving economic growth, comparable to investment in education. Similarly, [leading health bodies](#) around the world have been calling for a shift toward more prevention-focused and primary care for decades. While increasing the availability and early uptake of the interventions we outline in our research will not be easy, as Europe emerges from the COVID-19 crisis, Europeans have a once-in-a-generation opportunity to rethink the role of health in a postpandemic future and make changes.

The gravity of the COVID-19 crisis and the sense that many mature European health systems—long lauded as among the best in the world—[were exposed](#) as underprepared and poorly organized

Exhibit 6

In high-income countries, half or more of total health improvement from existing interventions could cost less than \$1,000 per DALY averted.

Cost-effectiveness and health improvement



Note: 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.
¹DALY = disability-adjusted life year (logarithmic scale).
²Pharmacological prevention of cardiovascular disease includes use of antihypertensives and statins (and/or other cholesterol-lowering medicines). Lifestyle changes include physical activity, diet, smoking cessation, and alleviation of other risks. These interventions are delivered as a combined program.
 Source: Reproduced with permission from Institute for Health Metrics and Evaluation. All rights reserved; ²Disease Control Priorities 3 (DCP-3): Economic evaluation for health, University of Washington Department of Global Health, 2018; Tufts Cost-Effectiveness Analysis Registry; Updated Appendix 3 of the WHO global

to respond to an emergency of this magnitude is already driving fresh thinking and energy for reform and investment in health systems resilience and security. In December 2020, the European Parliament agreed to a threefold increase in its budget for health (€9.4 billion from 2021–27) to fund the [EU4Health program](#) building on lessons learned during the pandemic. Its mission is to strengthen cross-border health cooperation, pandemic preparedness, data sharing, and systems resilience, including boosting primary care.

Health leaders have never been more politically relevant or enjoyed such a central strategic place in the regional and national debate on the management of the crisis and the economic and societal recovery that will follow. Building on this momentum, we identify four ways to capture the healthy growth opportunity:

1. **Invest in health and prevention while treating illness.** According to the OECD, the share of spending on health devoted to public health and prevention in Europe is too low, [estimated at less than 5 percent of total healthcare spending](#) in

Our methodology

Our analysis involves two main steps. First, we assess the potential to reduce the disease burden from known interventions as well as innovations. Second, we quantify the impact of the disease-burden reduction on economies.

Assessment of the potential to reduce the disease burden

We source our disease-burden forecasts to 2040 for each European country from the Global Burden of Disease data set developed by the Institute of Health Metrics and Evaluation (IHME) at the University of Washington. This data set includes diseases that cause death and contribute to years lived in poor health. We define diseases broadly as health conditions that affect quality of life, including infectious diseases, chronic conditions, and injuries.

To estimate the reduction in the disease burden achievable in our healthy-growth scenario, we conducted a detailed review of clinical evidence and guidelines to identify the interventions, both currently available and in the pipeline, with the greatest potential for scalable reduction of today's disease burden. We did so systematically for the top 52 diseases, which contribute to almost 80 percent of the global disease burden and 75 percent of the US disease burden, and relied on clinical guidelines and evidence from leading institutions such as the WHO, Disease Control Priorities Network, and The Lancet to estimate the health improvement potential. In all cases, our aim was to identify a basket of highly effective interventions with wide applicability, roughly 150 in total, rather than to

catalog all possible interventions that might be found in a well-resourced and comprehensive healthcare system.

For each individual intervention for the 52 diseases, we followed three steps. First, we sized the health-improvement potential. This is an estimate of the share of the disease burden that could be averted through rigorous application of an intervention affecting people with the disease. Second, we estimated the potential to increase adoption from current levels in countries that fall within four income archetypes (high, upper middle, lower middle, and low), with the United States considered part of the high-income archetype. For interventions that require ongoing compliance with a treatment program, this adoption estimate includes sustained adherence and not just initial uptake. Third, we estimated the time required to reach full impact. This involved two considerations: the time needed for implementation, and the time lag between delivering the intervention and gaining the health benefits from it. Where evidence on current or potential levels of adoption was limited, we made reasonable assumptions.

Quantification of the economic impact

To quantify the economic impact of these health improvements for Europe, we relied on population and labor-force forecasts to 2040 by country and incorporated the impact of health improvements by age group for each year. We then translated the improvements in population health to labor-force participation and labor productivity and to GDP through four channels:

fewer premature deaths; lower rates of disability among the working population; higher labor-market participation among healthier older people, informal caregivers, and people with disabilities; and higher productivity of a healthier workforce. The assumptions used to estimate impact across each of these channels were drawn from academic research where available and tested with an expert advisory group of economists.

Uncertainties in our analysis

A number of uncertainties are inherent in an attempt to understand how European health could be improved and what the benefits would be in 20 years. These arise from uncertainties surrounding the evolution of the European disease burden, the availability and effectiveness of different interventions (both those currently in use and those in development) 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:

1. **The evolution of the disease burden.** While McKinsey & Company employs many medical experts and scientists, we are not a disease forecasting firm. We rely on disease-burden forecasts by IHME, which maintains the most comprehensive database of the global disease burden. Forecasts of the global and European disease burden are inherently uncertain, and health shocks such as the COVID-19 pandemic may affect forecasts.

2. **The availability and effectiveness of interventions.** Our 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 of it, other aspects of our methodological approach influence our findings. We have mitigated them by sharing and reviewing our approach and interim results with academic and clinical experts at all stages of the research process and by providing [a detailed description of our method and sources in the technical appendix and bibliography of the global report](#).
3. **Future innovations.** Research and development in the life and medical sciences is inherently risky and uncertain. We attempted to constrain these inherent uncertainties by looking only at technologies at relatively later stages of development—those that had already passed initial hurdles—and by looking at defined yet relatively broad innovation categories rather than at individual products. We shared and reviewed our method and findings with experts in the field at all stages of the research.

4. **Economic potential.** In the economic analysis, we make assumptions about what labor-market choices people can make and choose to make if health benefits are 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. We addressed this uncertainty using a sensitivity analysis, based on a dynamic equilibrium economic model (for more details, see chapter 4 of the global report).

What this research does not do

This research does not forecast health trends. Its purpose is to provide a sense of the magnitude of potential health and economic benefits that could be achieved by more broadly applying known interventions. Our estimates are not predictions, and we recognize the significant changes needed to achieve the identified health gains in just two decades. We also recognize the risks and threats that could alter the underlying disease burden and the validity of our estimates. In particular,

the near- and long-term consequences of new diseases, such as COVID-19, and our response to them, will affect this underlying burden in ways that we cannot reliably quantify today.

This research does not assess current and future healthcare costs. Instead, we provide a high-level estimate of the cost implications of shifting to a healthy growth path by drawing on published research assessing the net cost for countries to implement the interventions identified. These implementation costs are incremental to current healthcare spending but could be largely offset by productivity gains in healthcare spending in middle- and high-income countries.

This research does not make recommendations about spending by any government or organization. It is intended to provide insight into what is possible to achieve with a broad-based improvement in global health. While our study provides a guide for how to improve the health of the world's population, every country in Europe has unique local health and economic conditions that should be considered to determine the most effective interventions in each case.

For more details about our methodology, see the [technical appendix of *Prioritizing health: A prescription for prosperity* \(MGI, July 2020\)](#).

most European countries. As a result, Europeans live with health conditions that could be avoided with greater support for smoking cessation, healthier diets, higher levels of physical activity, and early management with preventive medicines, which collectively account for about a third of the health improvement opportunity we size.

Yet there is an opportunity to build on and scale existing initiatives that promote health and prevention. For example, exercise programs have been proven to reduce fall risk and the severity of fall-related injuries in older adults, and while some are already in use in hospitals and residential care settings, these types of programs are still not widely available at scale for all who could benefit. Similarly, only a very small number of European countries—including [Finland](#) and [the United Kingdom](#)—have developed diabetes prevention programs at scale, while the Netherlands has introduced a fully reimbursed two-year lifestyle-based program for people with obesity. At the same time, it is critical to drive adoption of and adherence to effective therapies and to invest in [public health preparedness](#).

We anticipate a growing role for pan-European and international collaboration, knowledge and data sharing, partnerships and ecosystems that can help promote health and prevention. The EU Commission's EU4Health initiative is an early effort, and the WHO-Europe is also playing an important role in this regard, particularly in Eastern Europe. At the same time, an opportunity exists to further support and empower cities, and other local and place-based organizations are able to build community resilience. They design and deliver strategies that address locally relevant social drivers of health risks and poor health, including housing and the built environment, access to green spaces for exercise and recreation, and access to healthy food choices, employment, and educational opportunities. Across Europe,

we find [examples of investments](#) in urban design and planning that have a positive impact on health.

2. **Double down on innovation.** The pandemic has unlocked new opportunities to accelerate innovation. For example, digital and analytics can build on major shifts from in-person to virtual provision during the pandemic, and on much broader and timely use of data and analytics to manage capacity and risk. In France, for instance, regulatory changes made referrals and reimbursement far easier for virtual healthcare, and the legal validity of phone consultations was established and extended to broader groups of health professionals. Reimbursement for virtual consultations was introduced or widened in Poland, Austria, and Belgium, with a premium available in Portugal to promote uptake, and new pathways to reimbursement for a wide range of digital health technologies introduced in Germany. Governments increased funding for investment in digital technology for health in the United Kingdom and Greece, and clarified legal arrangements in Switzerland and elsewhere. The speed and breadth of strategies adopted provide a vivid illustration of the dramatic changes that are possible with concerted action and focus.

The pandemic has also unlocked new ways to accelerate research and better align the life sciences sector and societal health priorities by: (1) opening up new funding sources and risk-sharing models, such as advanced or partially guaranteed procurement; (2) running stages of development simultaneously rather than sequentially—such as starting manufacturing scale-up in parallel with late-stage clinical trials; (3) accelerating approval processes in part through early data sharing with regulators; (4) encouraging and supporting collaboration, transparency, and knowledge sharing; and (5) scaling up the use of advanced analytics and artificial intelligence (AI) in scientific discovery and the clinical trial process.

3. **Maintain health as a priority for all.** COVID-19 has put health on the agenda of every organization, large and small. Looking ahead, Europe must ensure that the health agenda remains a fundamental component of both the recovery and the “new normal.” Health, including mental health, should be top of mind in any decision-making process—for governments, companies, health institutions, investors, and societies. Long-term prevention and health promotion, and health security, cannot simply be left to healthcare providers or public health systems. It is, quite literally, everybody’s business.

Part of that endeavor means reframing the economic debate to ensure that health is understood as a growth lever and a critical component of economic and societal resilience and security. That means taking into account population health, health equity, and health security, and not just healthcare systems. Understanding that health is an investment and not just a cost can enable governments, companies, and communities to make the right decisions to drive long-term investment in health, kick-starting a virtuous cycle of health and economic prosperity.

4. **Improve healthcare productivity.** Public funds will be constrained in the coming years, and spending on healthcare represents about 10 percent of European GDP, according to the OECD. Even if new and better treatments emerge, that share is not likely to decline. Hence

there is a strong economic case to use those funds most effectively. There are a number of opportunities in the area of digitization and data. One example is bringing agile approaches and data exchange into European collaborations to enable collective action and responses to health emergencies and challenges, such as pandemics, cutting across silos and with higher speed. For example, in Denmark, [data is extracted for EHR](#) (electronic health record) systems to provide transparency on provider outcomes and quality. This not only puts relevant information in the hands of patients but at the same time acts as an incentive for providers to use and maintain the EHR systems from which the performance indicators are drawn. In the future, these types of capabilities, boosted by AI-driven algorithms, will be able to provide earlier warning signals of infectious disease outbreaks and richer insights into the risk factors associated with disease outcomes.

European citizens have, for the most part, long enjoyed universal health coverage and access to high-quality care. This does not mean that they have avoided widespread [health inequalities](#) experienced by members of society with lower incomes or belonging to marginalized communities, and cruelly [exposed during the pandemic](#). There is now an opportunity to rethink resource allocation, funding, and delivery models to achieve a fairer distribution of resources and outcomes, enhance value and improve access, and provide better health for all.

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