The aim of these background papers is to stimulate thinking and debate about the future of health and care. Each paper focuses on one area, summarising key narratives, tensions and debates raised in stakeholder interviews and discussions before the event.

Long-term trends

There are long-term trends that can be seen within health and care systems themselves, and also long-term trends in the external context to health systems. There is widespread agreement that it is valuable for health systems to consider, and where feasible respond to, these long-term trends, but also that it has proven **hard to do in practice**.

Within health systems

Technological innovation and its impact on the scope and nature of healthcare has been is a core driver of change in health and care systems. The nature of that innovation is evolving, with biomedical innovation being increasingly complemented by technological innovation (such as information and communication technologies). Emerging disease-modifying treatments for dementia will be a major shift that is likely to arise in the next 5-10 years. There are tensions between the perceived value of innovations that can improve health and the costs of new treatments, though innovations can also reduce the costs of existing treatments over time.

Rising public expectations of health and care are also a long-standing trend, perhaps now being amplified both by more rapid adaptation of services in other sectors (such as finance, travel) and greater awareness of what happens in other health systems. Greater public engagement will likely challenge existing systems for managing health and care systems, which are quite focused on technical and professional authority.

Demographic ageing is often described as the central challenge for health and care systems. Discussions in advance of this event suggest that it is not as significant a driver of overall costs and pressures as sometimes described. Ageing nevertheless raises important issues around likely health and care costs; how to add life to years, not just years to life; and how best to support people and their families at the very end of life to die with appropriate care and dignity. The implicit assumption of much healthcare discussion is that people want all possible care to prolong their lives. This is not necessarily the case.

The effect of demographic ageing on health care budgets is overestimated because of the compression of morbidity. As people live longer lives, the percentage of time lived with acute illness at end of life does not also lengthen. Another nuance is that people will have illness (such as cardiac illness) at 60 or 70 and recover to live another 20-30 years. The health budget is driven by

increasing costs of technology (including medicine) not ageing.

The nature of disease is shifting, with the rise of **non-communicable diseases and multi-morbidity** creating challenges for the traditional organisation and separations within health and care systems focused on individual conditions and episodes of care. There is increased understanding of the **social determinants** of health, and the ways in which wider economy and society affect health, but limited collective action to bring about change. Some areas of health remain relatively **neglected, such as mental health**. Despite repeated efforts, spending and activity remain concentrated overwhelmingly on care and treatment, rather than **prevention**.

The thing that worries me about the way in which our society is going is that the tools for being able to talk about collective action are disappearing. Everything gets redescribed in terms of the tools for manipulating individual choice. It all becomes about what the individual does and chooses. So forgetting the social institutions that matter.

Outside health systems

Income inequality has been rising around the world: for OECD countries, it is at its highest level for half a century. This creates challenges for health and care systems, not only in terms of need, but also in terms of whether increasingly unequal societies will continue to be willing to invest in social solidarity mechanisms such as collective health and care systems. And if not, what is the alternative? How far can and should health systems engage with these wider issues of inequality?

Inequalities are increasing. We can expect that this lack of trust is going to lead to more and more suffering that cannot be alleviated with a pill, but by addressing inequalities. Not just social determinants of health, but a more humanistic approach.

There is a **global shift in power and resources** away from historically developed countries to developing and emerging economies. As countries develop, so they face rising expectations about their health and care systems that are different from those of the past and from developed countries now. How will

emerging economies be able to establish universal health and care systems in this context? And what will be the consequences if they do not?

I like the idea that the GTC project is not focused on the developing world. Focusing on the developing world is a way of missing the problem. Instead of thinking about our problems, we do our good deeds in Africa. What you lose is a critical perspective when you start thinking about the developing world.

Climate change will lead to further pressures on many dimensions of societies and economies. This may involve the unexpected return of infectious threats or their movement to new parts of the world, and impacts on other natural resources such as air and water. As with inequality, large shocks from environmental pressures may undermine the collective basis of solidarity for health and care systems and other public services.

The biggest issue facing health and care over the next 50 years is climate change. I know that's not what you'd immediately jump to, but that is the global issue that's going to have the biggest impact on health and society. Climate change will affect health and care systems at so many levels. Resources to feed and house growing populations will be stretched as the natural world is disrupted, ecological diversity disappears… it will drive national fights for resources, disruption within countries and between countries.

Populism is a rising challenge to established norms of society and government, and to forms of authority such as scientific expertise. There has already been an impact on health and care with, for instance, the growth of the anti-vaccination movement and potential concerns about use and sharing of personal data. Will populism continue to grow? If so, how can health and care systems engage and respond to these kind of challenges? If not, what will replace it?

Will we have in our societies the basic solidarity that is needed to make the financing of health systems sustainable? Will people continue to contribute to a

health care system where we know that 70% of the budget is spent on 10% of the patients?

How to enable long-term thinking?

There is consensus on the **need for more long-term thinking**, but also that this is hard to do in practice. Constant pressures and short-term challenges tend to displace time to think about long-term issues unless this is specifically protected. **Learning from other systems** is widely seen as useful but underused. How can system leaders gain the time and space for long-term thinking, and to engage with wider issues? What needs to happen for health and care systems to do things differently?

All the pressure is on the immediate. You get innovative, academic clinicians saying we need to think about the future, but the pressures of the day to day overwhelm them. It is very hard to lift your head above the immediate, but important to do so.
